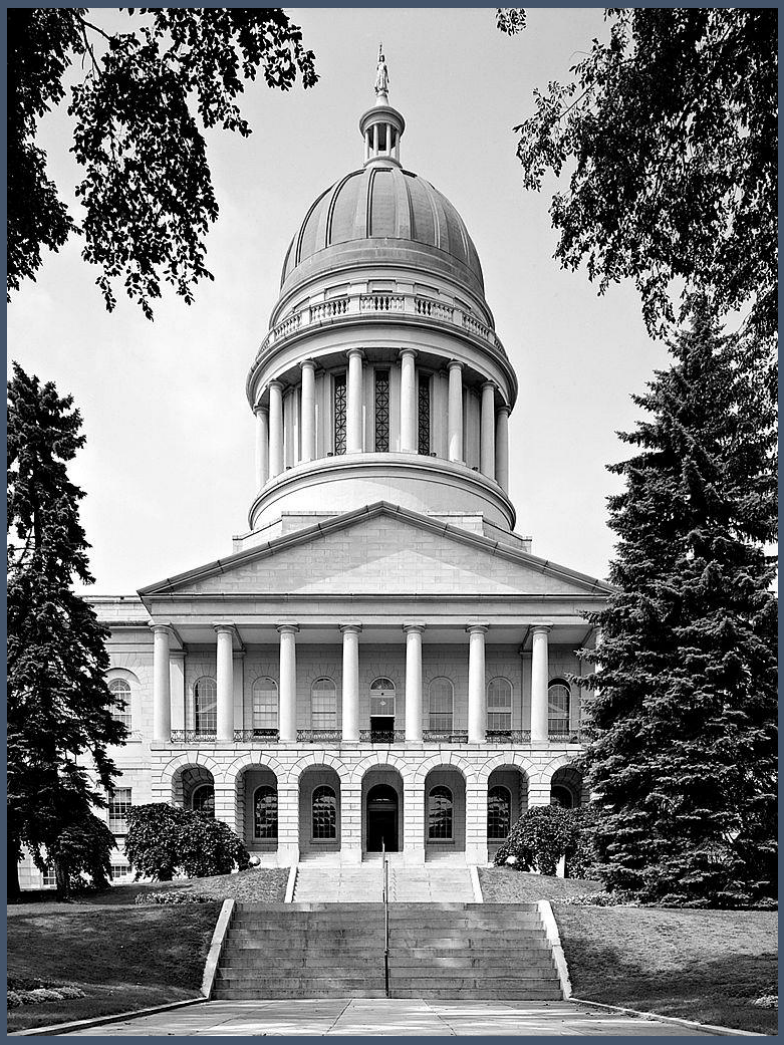

Maine State Capitol 1965
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Feasibility of Medicaid Expansion under the Affordable Care Act: A Review Submitted to the Maine Department of Health & Human Services

Final Report

Friday, January 10, 2014

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LIST OF ACRYONYMS

ACA	Affordable Care Act of 2010
AG	The Alexander Group
ARRA	American Recovery and Reinvestment Act of 2009
ASPE	Assistant Secretary for Planning and Evaluation, USDHHS
BIP	Balancing Incentives Program Grant
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program. Also known as SCHIP.
CMS	U.S. Center on Medicare and Medicaid Services
CY	Calendar Year
ESI	Employer-sponsored Insurance
DSH	Disproportionate Share Hospital
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
GDP	Gross Domestic Product
HCBS	Home and Community-Based Services
HIPP	Health Insurance Premium Payment
LTSS	Long Term Services and Support
MAGI	Modified Adjusted Gross Income
MDHHS	Maine Department of Health and Human Services

MMIS	Medicaid Management Information Systems
NASBO	National Association of State Budget Officers
NFIB	National Federation of Independent Business
OADS	Maine's Office of Aging and Disability Services
OMS	Office of MaineCare Services
PHIP	Maine Private Health Insurance Premium Program
PMPM	Average cost, Per-Month Per-Member
SAIPE	Small Area Income and Poverty Estimates
SFY	State Fiscal Year
SCHIP	State's Children Health Insurance Program. Also known as CHIP.
SPA	State Plan Amendment
USDHHS	United States Department of Health and Human Services

Foreword

Although an essential program for the poor and vulnerable, Medicaid has for years represented a significant budget challenge for state governments. As the assistance program has expanded, policymakers have attempted to limit or rein in funding to slow its growth; yet today Medicaid has replaced K-12 education as the largest financial item in states' budgets when all funds are counted. To reduce the fiscal impact, government officials have implemented numerous initiatives, including rate reductions, managed care to moderate utilization, pharmaceutical restrictions, and even imposing co-payments and cost sharing to introduce personal responsibility. Further, as the federal government has sought to reduce its share of payment, state governments have attempted to increase revenue by using practices that increase federal Medicaid spending with limited or no real state contribution. Despite these efforts, Medicaid remains a fiscal challenge to state policymakers as they also grapple with funding other budgetary priorities, such as education, transportation, and the environment.

Maine is no different; yet its case is more acute. Years of system changes, expansions, modifications, and even some achievements to more appropriately serve the physically and medically fragile, have left Medicaid's growth outpacing other major budget items, such as funding for K-12 education, which is necessary to achieve future economic growth and stability. Maine's Medicaid system, called MaineCare, is suffering from inadequate financial resources to maintain current commitments. Thousands of persons with intellectual disabilities are waiting for necessary services to help them live healthy and safely; physicians lack adequate reimbursement and are becoming scarcer for MaineCare enrollees; information-technology systems are in need of enhancements; and the elderly population is fast growing.

Like most states, Maine is in the midst of making a decision whether or not to expand Medicaid. For those states that have chosen to expand Medicaid, the Affordable Care Act (ACA), signed into law in 2010, transforms the program from a traditional program that serves the most needy and vulnerable to one that provides health-care coverage for everyone under the income threshold of 138% of the Federal Poverty level.

To ensure that the State considers all aspects of this important decision, the State of Maine's Department of Health and Human Services has engaged the Alexander Group to prepare a feasibility study and analyze the complexities associated with making this determination. Consequently, this feasibility study is offered to help policymakers make a more informed decision based on the evidence and the merits. Although we have reviewed the most salient aspects of expansion to date, new findings and information will continue to emerge that may influence our overall understanding of the issue.

Going forward, the Alexander Group will review such data and may apply those findings to improve our analysis and forecasts. Subsequently, the Alexander Group may periodically update this review to reflect such new information.

This feasibility study would never have materialized without the help of Mary Mayhew, commissioner of Maine's Department of Health and Human Service. She and her staff were invaluable in assisting us to obtain data and other information necessary for our analysis. Her department also reviewed a draft of this study. Pursuant to standard practice, we incorporated those recommendations from the department that we believed improved the report before submitting this final version. While we are indeed grateful for the assistance of the department, the Alexander Group takes full responsibility for all statements, opinions, evaluations, and analysis contained herein. As we worked diligently to adhere to the facts, we are prepared to support every statement made therein. If any factual errors are found, we take full responsibility and will issue corrective statements, if necessary.

Executive Summary

Background

Maine's Department of Health and Human Services has engaged the Alexander Group to prepare a feasibility study and analyze the complexities associated with expanding eligibility to its Medicaid program, i.e., MaineCare, pursuant to the Affordable Care Act of 2010 (ACA).

The Office of the Actuary of the U.S. Department of Health and Human Services predicts that if all states expand eligibility to Medicaid total enrollment would increase to an estimated 84.8 million in FFY 2021, for a 52.2% increase. The total cost would grow to $830.9 billion in FFY 2021, an increase of 94.4%. The actuaries noted that even if only those states comprising 65% of the Medicaid population decide to expand that Medicaid will grow faster than GDP, and they predicted that by 2020 it would comprise 3.2% of GDP, up from 2.8% in 2011.

For states, Medicaid has become the largest expenditure when all funding sources—including federal—are considered. Data from the National Association of State Budget Officers show Medicaid spending holds a substantial lead over the second largest state-budget category, i.e., primary and secondary education: 24.5% versus 20.0%. Maine's spending pattern preceded the national pattern by more than ten years when MaineCare overtook basic education spending as a percentage of the total budget in 1992. Also, Maine spends the third-highest percent of its total budget on Medicaid of all the states.

Fiscal issues are not the only challenge. A number of specialized Medicaid programs, including those in MaineCare, have long waiting lists. The low rate of payment to physicians has diminished the number of doctors willing to accept new Medicaid patients. Finally, federal Medicaid policy has historically favored costly institutional care, even in cases where individuals would be more appropriately served in less-restrictive home- and community-settings.

Summary of States' Experience with Expansion

According to the most recent information available, twenty-two states are not expanding eligibility for their Medicaid programs, three states are currently undecided, and twenty-five states are expanding in some form or another. To date, states that are expanding are experiencing challenges with their eligibility systems. However, states are reporting higher enrollment in Medicaid than in private insurance since the Affordable Care Act exchanges opened October 1, 2013. The report provides brief reviews of the experience of 25 states and the District of Columbia.

Results from the Financial Model

The Alexander Group developed a customized financial model to forecast enrollment and the associated fiscal costs of MaineCare. The Baseline assumes two programs are discontinued: (1) parents 101% to 138% of FPL, and (2) the Childless Adult Waiver.

Because of high poverty growth, the model predicts a significant growth in the Baseline. Thus, even without expanding eligibility, MaineCare enrollment is projected to grow by an annual average rate of 2.7%. Over nine years, this growth rate is a total increase of nearly 27%, which would add 85,700 persons to the enrollment, bringing the SFY 2023-24 Baseline enrollment to 406,100.

Under the Expansion Scenario, the population will grow more dramatically. The average annual growth becomes 5.2% over ten years, which would be a total increase of 66.7%. This would add a total of 212,100 persons onto the rolls over the ten year period, including the enrollment growth for the Baseline.

The AG Financial Model shows the total cost (all state funds plus federal funds) for the Baseline and Expansion Scenario will be significant. For the Baseline, total costs will increase on average of 5.5% per year, which increases the total cost by 70.5% over a ten-year period. Under the Baseline, the total cost for MaineCare increases by $1.9 billion, from $2.7 billion in SFY 2013-14 to $4.6 billion in SFY 2023-24.

For the Expansion Scenario, the total cost of MaineCare more than doubles by to $5.5 billion in SFY 2023-24, an increase of 105%.

For the Expansion Scenario, state costs would be $33.5 million in SFY 2014–15, or $45.3 million if the higher FMAP is denied for the childless adult waiver population when compared to the Baseline. The state costs are projected to grow to $125.0 million in SFY 2023–24, for a ten-year total of $807 million, or $840 million if the higher FMAP is denied.

Maine had 24.7% of its overall state population enrolled in MaineCare in SFY 2012-13. This percentage will grow to 29.0% by SFY 2023-24 under the Baseline. Under the Expansion Scenario, however, 37.9% of the overall state population will be enrolled in Medicaid.

In terms of state funds, the budget for MaineCare services has been growing faster than the rest of the state budget (6.0% average annual growth versus 2.2%). The AG Financial Model forecasts that the Baseline average annual growth rate will be 5.5%. However, if Maine elects to expand MaineCare eligibility, the forecasted growth rate becomes 6.2%.

The percentage of the General Fund budget dedicated to MaineCare services is projected to grow from 24.2% in SFY 2012–13 to 36.2% under the Baseline. Under the Expansion Scenario, however, MaineCare will require 38.7% of the General Fund budget. For the overall budget, including federal

funds, MaineCare will require 45.3% of the total budget under expansion in SFY 2023-24 as opposed to 40.2% under the Baseline.

One quick way to evaluate the economic impact is to compare MaineCare enrollment to employment. In SFY 2012–13, the ratio was 1 to 1.8, meaning that each person on MaineCare was supported by 2 employed persons. That ratio will drop to 1 to 1.3 in 2020 under the Expansion Scenario.

Risk Analysis

The scenarios generated by the financial model are based on a number of key assumptions on values of factors that will determine what trends will prevail in the future. Each value chosen was in the middle of an expected range of possibilities. There is risk, however, that the actual values that will be realized in the future will fall toward either end of the ranges as opposed to in the middle. Low-end values are defined as those values that would cause enrollment and costs to be lower than forecasted. High-end values are those values that would cause enrollment and cost to be more than forecasted.

Four risk factors chosen to be analyzed are the poverty growth rates, Per Member Per Month (PMPM) cost growth rates, individuals with private insurance losing coverage (private drop), and FMAP rate changes. In addition, two best case scenarios and two worst-case scenarios were run. The first set assumed that the three of those four risk factors will have values that fall on either the low-end or high-end of their respective ranges. The second set assumed that all four risk factors will fall on the low-end or high-end of their respective ranges.

Variance in the poverty growth risk factor would cause enrollment for the Baseline to vary from -5.9% to +6.2% off the middle by SFY 2023-24, and it would cause the state cost over the ten years for the Baseline to vary from -4.0% to +4.1% off the middle. Total expansion enrollment would vary from 117,100 to 131,300 in SFY 2023-24 as measured from the Baseline. State costs over ten years for the expansion would vary from $777 million to $837 million relative to the Baseline.

Variance in the PMPM cost risk factor would cause the state cost of the Baseline to vary from -6.4% to +6.8% off the middle over the ten years. The ten-year state cost for the expansion would vary from $750 million to $867 million as measured from the Baseline.

Variance in the private drop risk factor would cause the expansion enrollment to vary from 116, 000 to 144,200 by SFY 2023-24. State costs over ten years for the Expansion Scenario would vary from $764 million to $920 million relative to the Baseline.

Variance in the FMAP risk factor would cause the state cost of the Baseline to vary from -10.7% to +1.6% off the middle over the ten years. State costs over ten years for the Expansion Scenario would vary from $766 million to $2.45 billion relative to the Baseline.

The 3-out-of 4 best-case scenario assumed low-end values for the following risk factors: poverty growth, PMPM growth, and private drop. The 3-out-of-4 worst-case scenario assumed high-end values for PMPM growth, private drop, and FMAP. Variance in these best case / worst-case scenarios would cause enrollment for the Baseline to vary from -5.9% to 0% off the middle by SFY 2023-24, and it would cause the ten-year state costs for the Baseline to vary from -9.9% to 8.6. Total expansion enrollment would vary from 109,500 to 144,200 in SFY 2023-24 relative to the Baseline with 35.2% and 39.4% of the population enrolled in MaineCare, respectively. State costs over ten years for the expansion would vary from $685 million to $3.05 billion relative to the Baseline.

Variance in the 4-out-of-4 best case / 4-out-of-4 worst-case scenarios would cause enrollment for the Baseline to vary from -5.9% to +6.4% off the middle by SFY 2023-24, and it would cause the ten-year state costs for the Baseline to vary from -19.5% to +13.2% off the middle. Total expansion enrollment would vary from 109,500 to 152,700 in SFY 2023-24 relative to the Baseline, with 35.2% and 41.8% of the population enrolled in MaineCare, respectively. State costs over ten years for the expansion would vary from $649 million to $3.16 billion relative to the Baseline.

Conclusion

The AG Financial Model demonstrates that it will be challenging for Maine to afford MaineCare in the future even without expansion. Given current trends, MaineCare will comprise larger shares of Maine's General Fund budgets. Expanding eligibility will only exacerbate the trend, whereby MaineCare will comprise 38.7% of the General Fund budget in ten years. In addition, risk analysis shows that the best-case Expansion Scenario would still cost the state $649 million over the next ten years in addition to the cost of the Baseline. In total funds (all state and federal funds), the best-case scenario for expansion would have a ten-year cost of $6.3 billion. The worst-case scenario, however, would cost the state $3.16 billion over the next ten years in addition to the cost of the Baseline. In total funds, the worst-case scenario for expansion would have a ten-year cost of $9.4 billion.

The more pressing needs are restructuring and streamlining to make MaineCare more efficient and to deliver better quality outcomes. While health-care access and improved health outcomes remain an imperative, expansion of Medicaid may not be the best policy choice to achieve those goals. Other viable alternatives may allow Maine to improve access and quality while prioritizing needs and saving tax dollars. Consequently, Maine needs a state-based solution with flexibility from the federal government that focuses on access, transparency, quality, personal responsibility, and efficiency. That alternative would offer executive and legislative policymakers greater budgetary certainty, and allow them to focus on other fiscal and policy priorities.

Section I: Introduction

Overview

The Alexander Group (AG) was asked to "review the proposed Medicaid expansion currently offered under the Affordable Care Act and offer a feasibility study for Maine." MaineCare[1] is the Medicaid program for the State of Maine. The Affordable Care Act of 2010 (ACA)[2] mandates that states expand eligibility for their Medicaid programs to include all persons with incomes equal to or less than 133% of the Federal Poverty Level (FPL)[3] as defined by the law, plus a 5% income disregard effectively extending eligibility to 138% of FPL ($15,856 for an individual; $32,499 for a family of four in 2013.) The U.S. Supreme Court ruled that Congress exceeded its authority in mandating the expansion of eligibility, thus giving each state the choice on whether it wants to expand eligibility as defined by the ACA.

Medicaid in Brief

Medicaid[4] is a cooperative program between states and the federal government to provide health care benefits to low-income individuals who also meet eligibility requirements of predefined categories. In order to receive federal matching funds, states must provide benefits for numerous mandatory eligibility categories, which are often summarized as pregnant women, infants and children, low-income families, disabled individuals, and the elderly. Each mandatory population has its own set of eligibility rules.

States may also receive federal matching funds for programs that cover optional categories of individuals, and there is considerable variation and complexity in how these optional categories are defined. Federal law further provides for waivers to allow states some flexibility in designing programs outside current program parameters. These waivers require approval of the U.S. Department of Health and Human Services (USDHHS) in order to receive federal matching funds. States also are allowed to modify their Medicaid State Plan (the contract between the state and the Federal government that describes the state's Medicaid program) through something called the

[1] As used in this report, MaineCare includes all means-tested medical assistance programs administered by the Maine Department of Health and Human Services, including CubCare.

[2] The Patient Protection and Affordable Care Act, Public Law No. 111-148, was amended by the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152, and is referred to in this study as the Affordable Care Act (ACA).

[3] The U.S. Department of Health and Human Services annually publishes poverty guidelines in the Federal Register for administrative purposes of determining eligibility for various federal programs. These guidelines are often referred to as the Federal Poverty Level (FPL).

[4] Enacted in 1965, Medicaid is found in Title XIX of the Social Security Act. The Balanced Budget Act of 1997, Public Law 105-33, established the State Children's Health Insurance Program (SCHIP), which became known as the Children's Health Insurance Program (CHIP) after March 2009. Found in Title XXI of the Social Security Act, it is common to use CHIP and SCHIP interchangeably. Often, and in most contexts, CHIP is considered part of Medicaid.

State Plan Amendment (SPA) process. SPAs allow states to request basic program changes, make corrections, or send the federal government updates on their programs. Although waivers allow for more flexibility to test new and innovative models of care or new ways to deliver care, both the waiver and the SPA are referred to as the legal authority states possess to change their Medicaid programs.[5]

State participation in Medicaid is optional, but all states do participate.[6] The federal government provides matching funds via a formula using a three year average of state per capita income[7], known as the Federal Medical Assistance Percentage (FMAP). States with lower per capita incomes relative to the national average receive higher FMAPs while states with higher per capita income receive lower FMAPs. However, no state receives less than fifty percent. Generally, FMAPs vary from year-to-year based not only on annual fluctuations of per capita income but also due to changes in Federal law.[8]

The ACA and the Court Decision

The ACA is a complex piece of legislation having ten separate titles that comprise 907 pages in the consolidated version published by the U.S. House Office of the Legislative Counsel for the use of its attorneys and its clients. In its implementation, it has generated thousands of pages of federal regulations, and it impacts Medicare[9], Medicaid, the states that administer Medicaid, health-care providers, health-care device manufacturers, and potentially every citizen because of the

[5] Each time a state wants to make changes to its existing Medicaid system, it must go through these administrative processes with the Federal government. These processes are often times tedious, laborious, and outmoded.

[6] Arizona was the last state in the Union to implement Medicaid, doing so in 1982, 17 years after President Lyndon Johnson signed the program into law.

[7] Per capita income is mathematically determined by dividing total income by total population.

[8] A few examples include changes to the FMAP in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended), federal deficit reduction proposals originally offered in late 2011, which would amend the FMAP rate, and the disaster-related FMAP adjustment.

[9] Medicare and Medicaid should not be confused. Medicare is a federally run program to provide basic health care coverage for most Americans age 65 or older and certain groups of disabled individuals under 65 who are receiving social security benefits. Medicaid is a federal program to provide support to the states to run means-tested programs for specific categories of low income individuals and is the subject of this study and described in greater detail throughout this report. More formerly titled HEALTH INSURANCE FOR THE AGED AND DISABLED found in Title XVIII of the Social Security Act, Medicare was created as part of the Social Security Amendments of 1965 to provide health care coverage for aged persons to complement retirement, survivors, and disability benefits under Title II of the Social Security Act. In 1973, the program was expanded to include groups of individuals with disabilities, including those entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months and most persons with end-stage renal disease. The Program was expanded again in 2001 and 2010 to other small groups of individuals. Although Medicare has an established Trust Fund that initially was to be funded primarily from revenues collected from payroll deductions, currently at 2.9% of earnings, this is no longer the case. According to the *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund,* total expenses for Calendar Year 2012 were $574.2 billion, but revenue from payroll deductions equaled only $205.7 billion. The Trust Fund received $214.4 billion from general revenue of the federal government, $8.4 million from transfers from the states, and it still ran a $37.2 billion deficit. According to the report, the Trust Fund ended the year with assets of $287.6 billion, which are mostly held as Treasury notes and bonds guaranteed by the federal government. There were 42.1 million aged persons and 8.4 million disabled persons on Medicare for the calendar year.

widespread impact on the health-care industry and the many changes to the Internal Revenue Code that create new taxes and penalties. The impact on the states is quite extensive, requiring states to determine Medicaid eligibility by a new Modified Adjusted Gross Income (MAGI) methodology, to make numerous system changes to their Medicaid Management Information System (MMIS) for both claims and providers, and to adopt a new national coding system, to name a few.[10]

Title II, of the ACA, called the "Role of Public Programs," is a section of the law that makes significant changes to Medicaid. Most important for this study is the pre-Supreme Court ruling mandate that states must expand Medicaid eligibility to include all persons at 138% of FPL or below. When the ACA was passed into law, no state covered all persons at or below that defined income level. The penalty for states choosing not to expand would be the loss of all federal matching funds.

To the crafters of the ACA, Medicaid was an important piece of the law. It was the chosen mechanism to provide health insurance for all individuals at 138% of FPL or below as part of a plan to provide health care for all Americans. The ACA introduces new standards for employer-based insurance plans, and it mandated the creation of health care insurance exchanges, either federally or state run. These exchanges are intended to help individuals, families, and small businesses obtain health care insurance coverage.

The ACA has numerous financial incentives and disincentives. For example, employers with fifty or more employees will be penalized if they do not provide health care benefits. Notwithstanding some exceptions, individuals without health insurance as defined by the law would be subject to a tax penalty. It provides tax incentives for persons with income between 100% and 400% of FPL to purchase health care insurance. It provides significantly higher levels of FMAPs for states to help cover the cost of new populations enrolling in Medicaid, and it penalizes states who do not expand by denying them federal assistance for Medicaid.

Twenty-six states, several individuals, and the National Federation of Independent Business brought suit in Federal District Court, challenging the constitutionality of two aspects of the law: the individual mandate and the requirement that states must expand their Medicaid program.

On June 28, 2012, the Supreme Court issued its decision in *National Federation of Independent Business* v. Sebelius *(NFIB* v. *Sebelius).*[11] The issues were separately addressed. In a 5-4 decision, the Court ruled that the individual mandate penalty was not a penalty, as defined by the law, but rather a tax for constitutional purposes and thus was constitutional under the general taxing power of

[10] The American Action Forum provides one calculation on Maine's regulatory impact to be upwards of $119 million dollars through October 2012 requiring the equivalent of 97 workers to deal with the new work mandated by the ACA. See Sam Batkins, "State by State Impact of ACA Regulations," American Action Forum, October 2012, accessed at: http://americanactionforum.org/sites/default/files/ACA_regs.pdf.

[11] *National Federation of Independent Business v. Sebelius*, 567 U.S.11-393, June 2012.

Although the Supreme Court in *NFIB v Sebelius* decided that states possess a choice to expand or not, the expansion provision in the ACA still fundamentally transforms the program from one that covers the most vulnerable to one covering all citizens under 138% of the federal poverty level.

Congress. In a 7-2 decision, however, the Court ruled in favor of the claimants saying that the requirement that states expand Medicaid was unconstitutional.

In striking down the mandatory Medicaid expansion requirement, the Court underscored the fact that the Medicaid program was established to assist vulnerable citizens, defined as "pregnant women, children, needy families, the blind, the elderly, and the disabled," in obtaining medical care. While it is common for Congress to place limitations on federal funding, the Court has ruled over the years that the nature of the limitations must maintain a voluntary action on the part of the states or else it risks violating the state-federal relationship guaranteed by the Constitution. The following quote from the decision summarizes the legal logic.

> *"Therefore, if States really have no choice other than to accept the package, the offer is coercive, and the conditions cannot be sustained under the spending power. … In sum, it is perfectly clear from the goal and structure of the ACA that the offer of the Medicaid Expansion was one that Congress understood no State could refuse. The Medicaid Expansion therefore exceeds Congress' spending power and cannot be implemented."*[12]

The effect of the court decision in *NFIB* v. *Sebelius* is that states have a choice on whether or not to transform their Medicaid program from a program to assist mandatory and optional categories of individuals into a program to provide health-care coverage for everyone under the federally established income level, and Congress is prohibited from penalizing states that decline the offer.

Importance of Feasibility

The decision to expand eligibility for Medicaid involves multiple layers of complexities. MaineCare is very complex as is the ACA and the health care industry itself, especially as configured in the United States. In addition, MaineCare is just one part of a larger welfare assistance system, compounding the complexity. Overlaying these complexities are a fundamental policy controversy over what kind of health care system can best provide for society, not only in regard to providing health care but also on its impact on the economy. The opinions on the matter vary widely, ranging from those who prefer pure market forces to those who advocate for a command system totally run by the government.[13] The question has become highly politicized, as expected, but the politicization

[12] Ibid, pp. 35 and 46.

[13] To read opposing views of a free market system and a single payer government system, See D. Eric Schansberg, "Envisioning a Free Market in Health Care," *Cato Journal*. Vol. 31. No.1 (2011) and "How Single-Payer Health System Reform Improves Quality." Dr. Gordon Schiff and the Physicians for a National Health Program (PNHP) Working Group on Quality. Adapted from "A Better Quality Alternative: Single-Payer Health System Reform," *Journal of the American Medical Association,* September 1994. Accessed at: www.pnhp.org/facts/quality.pdf.

can become problematic if policymakers begin to ignore facts and empirical findings in favor of philosophical notions.

Although the ACA became politically divisive from its inception, it seems to align well with those who have philosophical leanings toward expansive government-run systems. The purpose of this study, however, is to provide factual, analytical, and empirically-based evidence to help the Governor and policymakers understand the potential financial, operational, and performance implications and challenges that will have longstanding effects on the economic future of the State of Maine and its citizens.

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Section II: Medicaid Finance and Outcomes—National Perspective

Overview

This section provides a high-level overview of the finances, outcomes, and special issues relating to Medicaid programs from a national perspective as well as the view from the states, with a special emphasis on the State of Maine.

Official US Government Forecast

The Office of the Actuary of the U.S. Department of Health and Human Services annually publishes an actuarial report on Medicaid that provides a forecast on both enrollment and Medicaid costs. While there are competing forecasts available, and perhaps some may ultimately prove to be more accurate, the official forecast is nonetheless appropriate to use for the purpose of obtaining a picture of how enrollment and costs will track and trend in the future. Clearly, the predictions may not all turn out to be completely accurate, but forecasting is not an exact science and it would be difficult to know which other forecasts may be more reliable.[14]

An important challenge faced by the USDHHS actuaries in producing this report[15] was determining the number of states that would decide to expand eligibility pursuant to the ACA. They resolved the issue by assuming "55% of potentially newly eligible enrollees reside in States that would expand Medicaid eligibility in 2014 and that 65% reside in States that would expand eligibility in 2015 and later years." Thus, three scenarios were created: (1) no states expand pursuant to the ACA (labeled as the "*no expansion*" scenario), (2) some states comprising ultimately 65% of the eligible population expand (labeled the "*baseline*" scenario), and (3) all states expand (labeled the "*full expansion*" scenario).

As shown on the chart in **Figure 1**,[16] the Office of the Actuary forecasts that the Medicaid enrollment will expand from 55.7 million in Federal Fiscal Year (FFY) 2011 to 77.9 million in FFY 2021 under the *baseline* scenario, which is a 39.8% increase. Under *full expansion*, total enrollment would increase to an estimated 84.8 million in FFY 2021, for a 52.2% increase.

[14] Forecasting allows states to adjust future expectations based on past and or recent performance.

[15] Office of the Actuary, Centers for Medicare & Medicaid Services, United States Department of Health & Human Services, *2012 Actuarial Report on the Financial Outlook for Medicaid*, by Christopher J. Truffer, F.S.A., John D. Klemm, Ph.D., A.S.A., M.A.A.A. Christian J. Wolfe, A.S.A., Kathryn E. Rennie and Jessica F. Shuff. 2012. Accessed at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2012.pdf

[16] Ibid, p. 40.

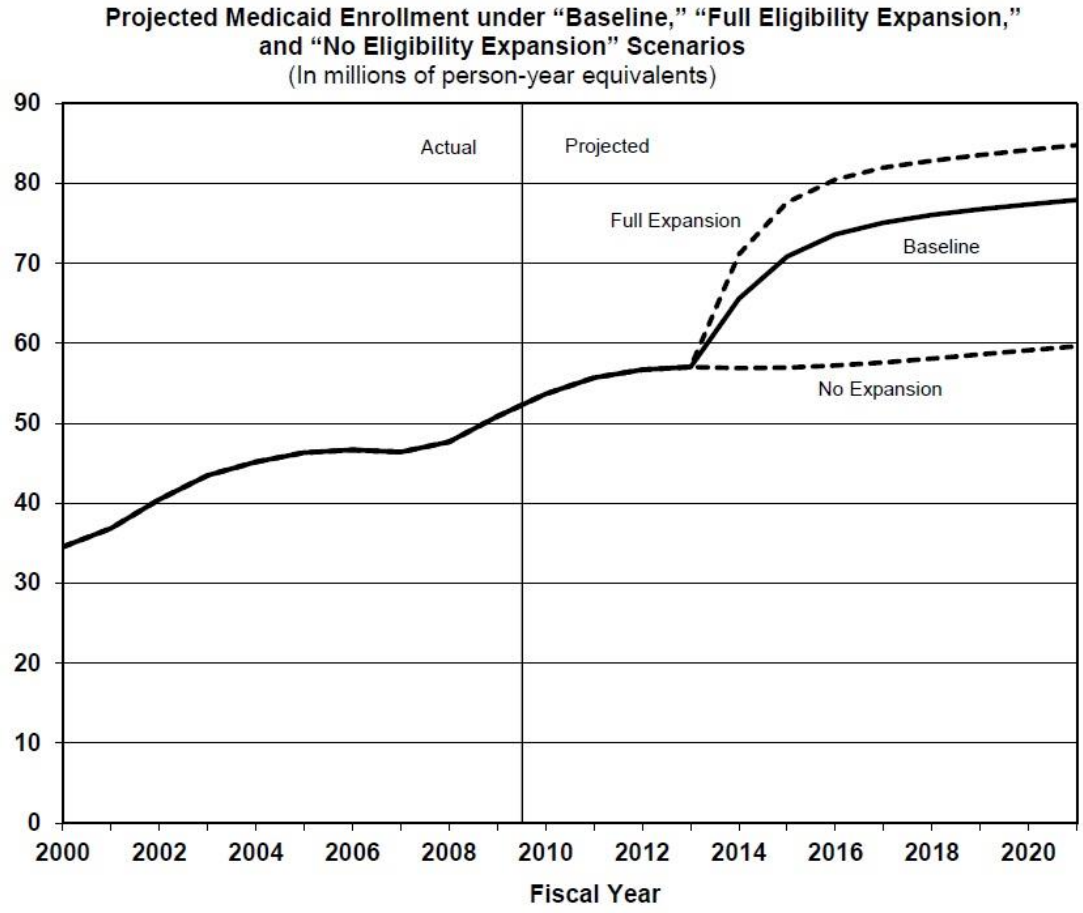

Figure 1: Projected Medicaid Enrollment – Millions of Persons

According to the actuarial report, the total program cost of Medicaid is projected to increase by 86% from $427.4 billion in FFY 2011 to $796 billion in FFY 2021 under the *baseline* scenario. However, it would grow to $830.9 billion in FFY 2021, under the *full expansion* scenario, which is nearly double—an increase of 94.4%. The forecasted growth of the three scenarios are illustrated in the chart in **Figure 2**.[17]

According to the 2012 USDHHS Actuarial Report the total program cost of Medicaid, if all states expand, is projected to nearly double from $427.4 billion in FFY 2011 to $830.9 billion in FFY 2021, an increase of 94.4%.

As is obvious from studying the previous two charts, the *expansion* population cannot explain the entire increase in the expenditure growth. The actuaries identified what they called the most important three causal factors: expansion of the eligible population, inflationary pressures within the health-care industry, and utilization. To quote from the report: "During 2012 through 2021, Medicaid expenditure growth is projected to be 6.4% per year on average, 1.1 percentage points higher than it would be if the Affordable Care Act impacts were excluded (5.3% average growth)."[18]

[17] Ibid, p. 39.

[18] Ibid, p. 42.

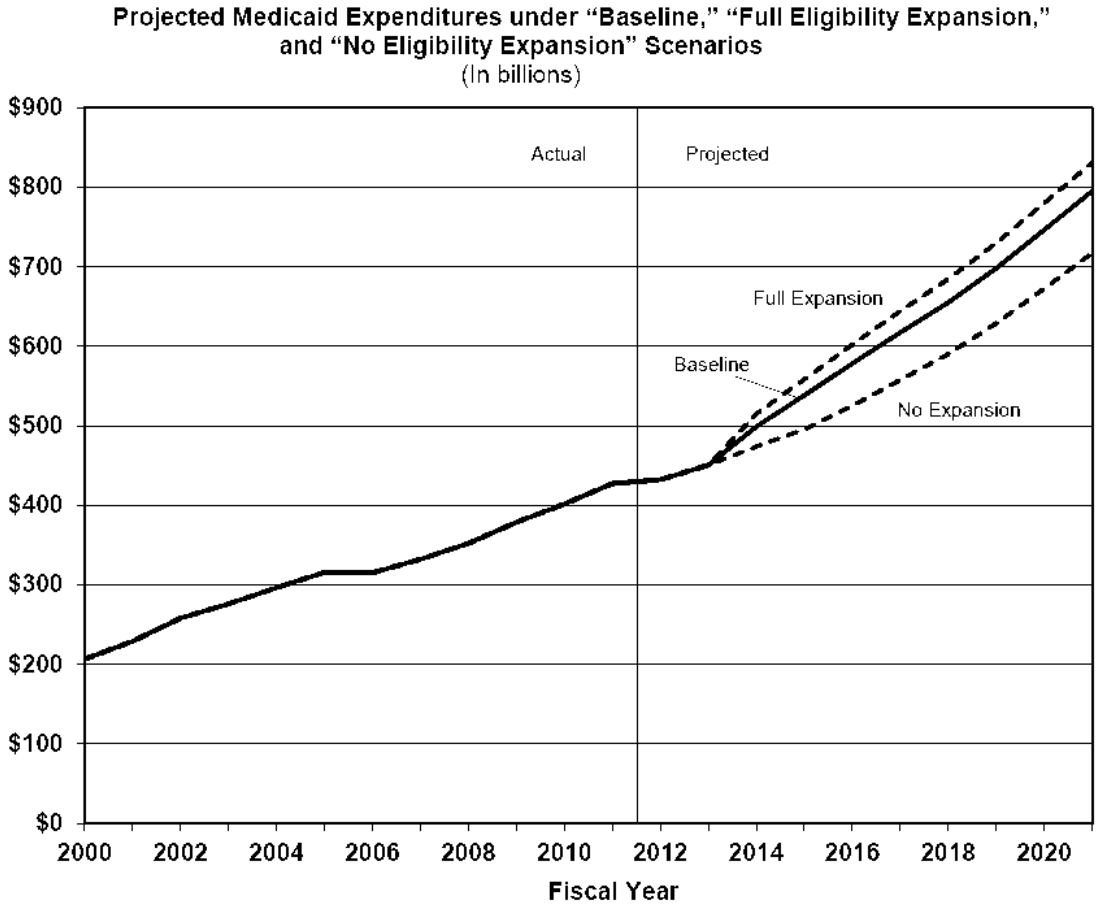

Figure 2: Projected Medicaid Expenditures – in Billions of Dollars

While the projected growth may be startling to some, USDHHS actually lowered its forecast significantly from its 2011 report for the following reasons in order of importance: (1) states' extensive efforts to lower costs and reduce payments in 2012 were greater than anticipated, and these reductions were incorporated into the forecast; (2) The actuarial report reduced its estimates on the number of states that would expand pursuant to the ACA; and (3) USDHHS is expecting slower overall healthcare expenditure growth.[19]

The report further compares Medicaid growth to the Gross Domestic Product (GDP), which is produced by the U.S. Bureau of Economic Analysis and measures the total market values of all final goods and services produced within U.S. borders. Medicaid, both in federal and state resources, has been requiring steadily more economic resources over the years: in 1970, it represented 0.5% of GDP; in 1980, 0.9%; in 1990, 1.2%; in 2000, 2.1%, and in

By 2020, Medicaid will reach 3.2% of GDP with only a partial expansion by the states representing 65% of the Medicaid population.

[19] Ibid, pp. 44-45.

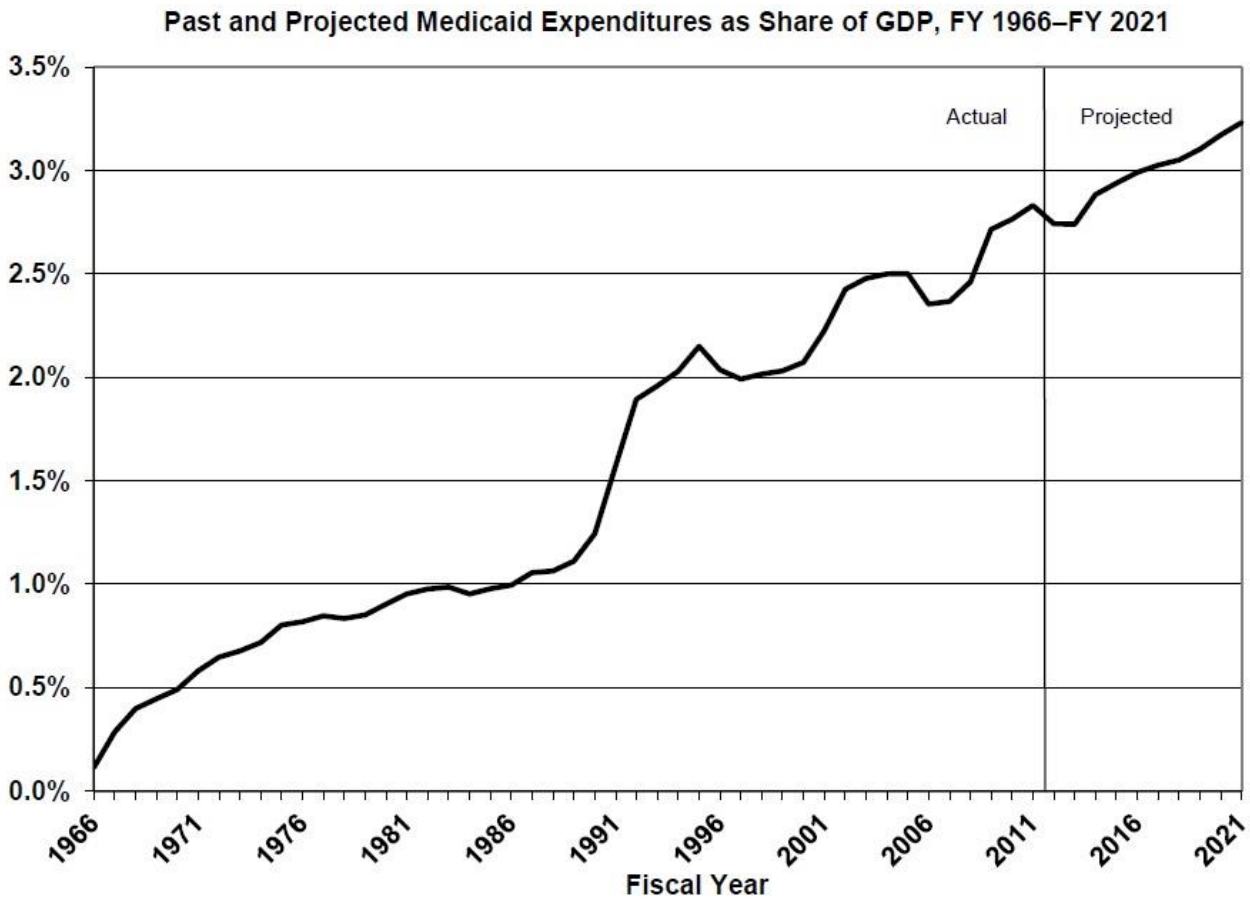

Figure 3: Medicaid Expenditures as Share of GDP

2011, 2.8%. The actuaries noted that even if only those states comprising 65% of the Medicaid population decide to expand that Medicaid will grow faster than GDP, and they predicted that by 2020 it would comprise 3.2% of GDP, up from 2.8% in 2011. The report also noted that while Medicaid expenditures have declined somewhat from earlier projections, they are still projected to increase at an average annual rate of 6.4% per year through 2021. GDP, however, is anticipated to grow annually by only 5%. Even this assumption may be optimistic because GDP has not grown annually by 5% since prior to the 2007 recession. The chart shown in **Figure 3** illustrates how Medicaid expenditures have been outpacing GDP.[20]

[20] Ibid, p. 50. For 2013, health care spending growth is projected to remain under 4% because of the sluggish economic recovery, continued increases in cost-sharing requirements for the privately insured, and slower growth for Medicare and Medicaid spending. Starting in 2014, however, growth in national health spending will accelerate to 6.1%, reflecting expanded insurance coverage and growth through the ACA, through either Medicaid or the marketplaces. The use of medical services and goods, especially prescription drugs and physician and clinical services, among the newly insured is expected to contribute significantly to spending increases in Medicaid (12.2%) and private health insurance (7.7%). Out-of-pocket spending is projected to decline 1.5% in 2014 due to the new coverage and lower cost sharing for those with improved coverage. C. Fleming. "US Health Spending Growth Projected to Average 5.8 Percent Annually Through 2022," *Health Affairs Blog online*, September 18, 2013.

Federal Budget Deficit and National Debt

Economists, in general, are not against federal deficits provided (1) those deficits do not become the norm and (2) the magnitude of the debt remains

Forty-eight states, including Maine, have constitutional or statutory provisions requiring balanced budgets, and the two without such provisions have balanced their budgets in practice.[21] The federal government, however, has no such constitutional restriction, and in practice it has not exercised the discipline to balance the budget on a consistent basis since the 1920's, with two exceptions. From FFYs 1947 through 1960, the federal government ran surpluses half the time and the aggregated surpluses nearly equaled the aggregated deficits. The second exception is a brief period from FFY 1998 through FFY 2001 when the federal government ran surpluses.

Although there is disagreement among economists on the effectiveness of deficit spending to stimulate the economy during recessionary times, economists do seem to agree on a number of other principles relating to deficits and debt. Economists, in general, are not against federal deficits or the national government assuming debt, provided (1) those deficits do not become the norm and (2) the magnitude of the debt remains manageable. They usually describe their concerns in terms of structural deficits, that is, when there is consistent deficit spending on an annual basis during good economic times and bad. They are not alarmed if the federal government carries debt, but they become concerned when that debt becomes so large relative to the economy that it begins to restrict fiscal flexibility and causes unwelcomed economic consequences.

For example, most people can carry a debt load. They can afford to borrow money to buy a house and a car as long as they have adequate income to make loan payments. They can spend more in a year than they make, provided they manage their finances over their lifetime and make more money than they spend in other years. The federal government has a greater ability to carry debt and run deficits for at least two important reasons. First, it has no expected lifespan when all debt must be repaid, that is, when a person dies. Second, it has a number of tools available to it to maneuver financially that are not available to individuals, such as monetizing debt.

Governments, however, can still overextend themselves, and they certainly do. On the first point of not allowing deficits to become the norm, it is commonly accepted that the federal government has a structural deficit problem.

[21] Forty-three states have constitutional provisions relating to a balanced budget, five states have statutes but no constitutional provisions, and just two have neither. Of the two that have neither: Indiana may carry over annual deficits but cannot assume debt, which has the effect of forcing budgetary discipline; and Vermont, in practice, has not carried deficits from one budget year to the next. Restrictions relating to balanced budgets may be on the Governor when he introduces the budget (44 states), on the Legislature to pass a balanced budget (41 states), or on the Governor when he signs the budget (37 states). National Association of State Budget Officers, "*Budget Processes in the States*," Summer 2008.

Top 10 Largest Federal Deficits Since FFY 1940					
Rank	FFY	Inflation Adjusted Billion Dollars Base Year 2013	Rank	FFY	Percent of GDP
1	2009	-1,517	1	1943	-30.3
2	2010	-1,373	2	1944	-22.7
3	2011	-1,351	3	1945	-21.5
4	2012	-1,104	4	1942	-14.2
5	2013	-680	5	2009	-10.1
6	1943	-632	6	2010	-9.0
7	1945	-625	7	2011	-8.7
8	1944	-596	8	1946	-7.2
9	2004	-509	9	2012	-7.0
10	2008	-494	10	1983	-6.0

Figure 4: Top 10 Largest Federal Deficits Ranked in Two Ways

Over the last fifty years, the federal government ran deficits ninety percent of the time, during good economic times and bad. In inflation adjusted dollars, the six of the ten largest federal deficits since 1940 include FFYs 2008 through 2013, and five of those years hold the top five spots. As shown on the left half of the table in **Figure 4,** the largest federal budget ever was FFY 2009, which was -$1.5 trillion when adjusted for inflation in 2013 dollars.[22] Economists generally believe, however, that comparing magnitudes of inflation-adjusted deficits over time may be misleading because it does not account for the growth of the economy. Therefore, they like to compare deficits to the Gross Domestic Product (GDP). As shown on the right half of the table in **Figure 4**, recent deficits are still enormously large. The top four years with the largest deficits were during trying times of World War II: 1942 through 1945. The next three years, however, are 2009, 2010, and 2011.

On the second point, relating to having a national debt that is manageable, economists like to compare total national debt to GDP. Against this metric, the United States does not do well at all. For the second quarter of 2013, the debt-to-GDP ratio was 100.6%. Five years ago, the debt-to-GDP ratio was only 64.8%. This calculation uses both debt held by the public and by the government itself, which is known as intra-governmental debt. The latter debt consists of true obligations held by various government agencies, including the trust funds of Social Security and Medicare.

It is commonly accepted that the federal government has a structural deficit problem. Over the last fifty years, the federal government ran deficits ninety percent of the time.

[22] Data here and in the chart come from three sources: U.S. Office of Management and Budget, *Fiscal Year 2014 Historical Tables, Budget of the U.S. Government*, Table 1.3; Congressional Budget Office, *Monthly Budget Review—Summary for Fiscal Year 2013*, November 7, 2013; and Gross Domestic Product data from the U.S. Bureau of Economic Analysis. All values were converted to base FFY 2013 using GDP price deflators.

If the United States were a member of the European Union, it would have the sixth worst debt-to-GDP ratio after Greece, Italy, Portugal, Ireland, and Belgium.

A comparison of the United States to other countries also illustrates the point. If the United States were a member of the European Union, it would have the sixth worst debt-to-GDP ratio after Greece, Italy, Portugal, Ireland, and Belgium, as indicated in the table in **Figure 5** which compares the second quarter of 2013, the most recent data available.[23] Note on the list that the countries closest to the U.S. are countries struggling with serious economic problems.

Government Debt to GDP 2013 Q2 Comparing US to EU Countries		
Rank	Country	%
1	Greece	169.1
2	Italy	133.3
3	Portugal	131.3
4	Ireland	125.7
5	Belgium	105.0
	United States	**100.6**
6	Cyprus	98.3
7	France	93.5
8	Spain	92.3
9	United Kingdom	89.6
10	Hungary	81.6

Figure 5: Compare US Debt/ GDP Ratio to EU Countries

The history of Congressional actions to solve the continual deficit challenges, which have been mostly unsuccessful, is long and will not be covered here. However, it is important to know about recent attempts that may have an impact on future spending on Medicaid.

First proposed by President Bill Clinton[24] as part of his 1997 budget proposal, *per capita* caps would transform Medicaid's financing mechanism by limiting each state to fixed dollar reimbursements for each recipient as opposed to the current method of paying for a percentage share of the costs. In essence, program spending growth would be linked to enrollment, not the overall cost of spending. Although *per capita* caps have been utilized in select Medicaid demonstration projects to ensure federal expenditures do not surpass a specified total, they have never been applied to the entire program. While *per capita* caps are typically proposed to save the federal government money, states would most likely have to make up the difference.[25]

Different methodologies can be utilized in determining *per capita* caps. One method would establish a federal reimbursement limit per each recipient, and states would be responsible for any amount spent over that limit. Some methods would take into account the historic per-recipient Medicaid spending of the states, establishing limits on a state specific basis. Other methods would set up separate caps based on specific population groups.

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[23] EuroStat, European Union, Luxembourg, "Euro area and EU28 government debt up to 93.4%and 86.8% of GDP," *EuroStat News Release*, 153/2013, October 23, 2013. U.S. Debt calculated using http://www.treasurydirect.gov/ website of the U.S. Department of Treasury. Accessed December 10, 2013. GDP data from U.S. Bureau of Economic Analysis.

[24] When the GOP-controlled Congress passed a Medicaid block grant bill in the late 1990s, President Clinton vetoed it and in response proposed his *per capita* cap method as a compromise. Under the President's proposal, the caps would be calculated for spending on specific eligibility groups, such as individuals with disabilities, non-disabled adults, children, and the elderly.

[25] Edwin Park and Matt Broaddus, "Medicaid Per Capita Cap Would Shift Costs to States and Place Low-Income Beneficiaries at Risk," Center *for Budget and Policy Priorities,* October 4, 2012.

Although the implementation of *per capita* caps would provide states with stricter spending limits, typical proposals have allowed increased flexibility to avoid federal rules around cost sharing and the modification of benefits. Flexibility with federal eligibility rules however, would most likely not be granted, thus assuring the continuation of historic caseload growth and a significant loss of federal dollars to states.[26]

Although Medicaid was exempted in the 2011 Deficit Reduction plans, there is no guarantee that Congress will be able to exempt Medicaid from budget cuts in the future.

Congressman Bill Cassidy from Louisiana provides a recent example of how this cost saving initiative continues to resurface when in 2012 he proposed to equalize Medicaid spending across all states with a *per capita* cap that varied by Medicaid category.[27] His proposal called for *per capita* caps that differed for eligibility groups, such as children, adults, the blind and individuals with disabilities, and elderly individuals receiving long-term care services, based on the median cost of care.[28] Payments under his proposal would be "risk adjusted for the population as well as down to the recipient."[29] More recently, on May 1, 2013, Senator Orrin Hatch (R-Utah) and Representative Fred Upton (R-Mich.) made public a plan for "Making Medicaid Work". One of their blueprint's key proposals was to implement per capita caps.[30]

Historically, times of federal financial crises have been the main rationale for imposing *per capita* caps. Certain policymakers, however, believe that in addition to saving money, they would improve care. Although no *per capita* cap proposal has been implemented across the entire program to date, the growing federal budget deficit—as well as a fundamental belief by certain policymakers that caps incentivize improved outcomes—makes certain that *per capita* caps will continue to be offered as a solution to the current fiscal challenges faced by the federal government.

In 2011, debate over raising the debt ceiling of the federal government led to a compromise. In exchange for raising the ceiling, Congress created a Joint Select Committee on Deficit Reduction with the enactment of the Budget Control Act of 2011. The Select Committee was charged with

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[26] Even though per capita caps normally impose a limitation on state flexibility to make significant changes to the system, it is possible (although not probable) that Congress could amend federal law to allow modifications to enrollment and eligibility.

[27] Bill Cassidy, "Cassidy Eyes Per Capita Caps For States As Part Of Medicaid Reform Proposal," *Inside Health Policy*, March 6, 2012, accessed at: http://insidehealthpolicy.com/Inside-Health-General/Public-Content/cassidy-eyes-per-capita-caps-for-states-as-part-of-medicaid-reform-proposal/menu-id-869.html

[28] Critics of per capita caps have argued that they do not take into consideration unanticipated health care cost growth or future demographic changes.

[29] *Idem.* Also, Congressman Cassidy claimed that under his proposal the money would follow the patient and produce better outcomes.

[30] Senators Fred Upton and Orin Hatch, "Making Medicaid Work: Protect the Vulnerable, Offer Individualized Care, and Reduce Costs," May 1, 2013, accessed at:
http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130501Medicaid.pdf

developing and proposing a bipartisan budget to reduce the budget by $1.5 trillion over ten years. If the Select Committee failed by January 15, 2012, to have legislation enacted that would achieve a $1.2 trillion deficit reduction, the Act triggered automatic reductions in defense and other discretionary spending spread evenly over FFYs 2013 through 2021, also known as "*sequestration*." The Act exempted Medicaid from the automatic spending cuts. The Select Committee failed, triggering the automatic spending cuts.[31] With the help of *sequestration*, the current federal deficit in FFY 2013 was reduced to $680 billion, which was the first time it fell below $1 trillion since FFY 2008. However, FFY 2013 is still the fifth largest budget deficit in inflation-adjusted dollars since 1940, and the 18th in terms of a percent of GDP.

Although Medicaid was exempted in the 2011 Act, there is no guarantee that Congress will be able to continue exempting Medicaid from budget cuts in the future. Medicaid competes against other priorities also considered to be very important, including Medicare, federal pensions, veteran benefits, food assistance, and housing. Additionally, the continued cost escalation brings even greater attention to Medicaid.

Figure 6[32] for example, lists Medicaid as having the highest percentage increase in expenditure growth of all major budgetary categories for both FFYs 2012 and 2013. Considering that the national debt grew at 5.4% from December 2012 to December 2013 while GDP has only grown 3.3% (or 1.8%

Total Outlays
(Billions of dollars)

Major Category	2011	2012	2013	Percentage Change, 2012–2013 Actual	Percentage Change, 2012–2013 Adjusted
Defense-Military	678	651	608	-6.6	-7.2
Social Security Benefits	720	762	803	5.3	5.3
Medicare	483	469	495	5.6	2.3
Medicaid	275	251	265	5.9	5.9
Unemployment Benefits	126	96	72	-24.7	-24.7
Other Activities	1,088	1,027	1,058	3.0	2.5
Subtotal	3,370	3,256	3,300	1.4	0.7
Net Interest on the Public Debt	266	258	259	0.4	0.4
TARP	-38	24	-9	n.m.	n.m.
Net Payments to GSEs	5	0	-97	n.m.	n.m.
Total	**3,603**	**3,538**	**3,454**	**-2.4**	**-3.0**
Percentage of GDP	23.4	22.0	20.8	n.a.	n.a.

Sources: Congressional Budget Office; OMB; Department of the Treasury.

Note: n.m. = not meaningful; n.a. = not applicable. TARP = Troubled Asset Relief Program; GSEs = government-sponsored enterprises, Fannie Mae and Freddie Mac.

Figure 6: Total Outlays from Federal Government 2011-2013

[31] The American Taxpayer Relief Act of 2012, which was passed on January 1, 2013, delayed sequestration from January 2, 2013, until March 1, 2013.

[32] Congressional Budget Office (CBO), *Monthly Budget Review,* November 7, 2013.

if you adjust for inflation), the national debt continues to grow faster than GDP, placing pressure on Congress to act on the deficit problem.

The November 2013 Congressional Budget Office Report states that Medicaid is expected to grow at an average rate of 8% over the next decade, nearly 2 percentage points higher than the USDHHS' Actuarial Report..

The numbers alone call attention to the Medicaid program, and the solution from the point of view of the federal government is obvious. Federal deficits continue to mount, adding to the national debt at a faster rate than GDP growth, and Medicaid is the fastest growing budget category. Just recently, the Congressional Budget Office suggested an option to impose a cap on federal Medicaid spending to help bring the federal deficit problem under control.

In November 2013, the Congressional Budget Office published the report *Options for Reducing the Deficit: 2014 to 2023*, and the very first option listed under the category of health is capping Medicaid spending.

The report points out that "CBO expects federal Medicaid to grow at a higher rate over the next decade, an average of 8% a year." Note that this forecast is almost two percentage points higher than the forecast by the USDHHS's Office of the Actuary covered earlier in this section. The quote below is from the CBO report.

> *"Lawmakers could make various structural changes to Medicaid to decrease federal spending for the program. Those changes include reducing the scope of covered services, eliminating eligibility categories, repealing the Medicaid expansion due to start in 2014, lowering the federal government's share of total Medicaid spending, or capping the amount that each state receives from the federal government to operate the program."*[33]

The report discusses in great length the pros and cons with specific recommendations on ways to cut back on Medicaid spending. One obvious way would be to reduce FMAPs. Clearly, there is risk that Congress may shift more costs of Medicaid to the states, and **Section VI** of this report will address that risk more fully.[34]

[33] Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023*, November 2013.

[34] Especially when one considers that the ACA's Medicaid expansion funding is at 90% to 100%, it would be hard pressed for any Congress or President to increase funding. The only way to move at this point would be to reduce funding.

Perspective from the States

Health care and its ancillary support services are the largest items in states' budgets, and it is noteworthy that one of the conclusions of the official actuarial report on Medicaid involves the budgets of the states:

> *"Despite the amount of time that has passed since the end of the recession, some of its effects on Medicaid still remain. Enrollment is projected to have grown more quickly than the U.S. population in 2012, albeit at slower rates than in recent years. The expiration of the temporary Federal matching rate increases led to substantial increases in State Medicaid expenditures, but States' budget revenues have not kept pace; these conflicting trends appear to have been a significant reason for the relatively slow rate of Medicaid expenditure growth in 2012."* [35]

According to the National Association of State Budget Officers (NASBO), in 2003 Medicaid surpassed elementary and secondary education (basic education) to become the largest state budgetary Program.

As can be expected, Medicaid expenditures have been a major concern of the states. The National Association of State Budget Officers (NASBO) produces periodic information on the fiscal situation of the states, and Medicaid has played a central role in those publications. The most recent State Expenditure Report, published in November 2013, shows that once again Medicaid is the largest component of states' total budgets (consisting of all funds, including federal funds), comprising on average 24.5%, i.e., almost one in every four dollars that a state spends goes to Medicaid. The growth has been steady over time. In 1990, Medicaid surpassed higher education as the second largest state program, and in 2003 it surpassed elementary and secondary education (basic education) to become the largest program. For the next several years, basic education and Medicaid traded places, but now Medicaid holds a substantial lead over basic education: 24.5% versus 20.0%.[36]

[35] *2012 Actuarial Report on the Financial Outlook for Medicaid,* p. 52.

[36] The growth of the Medicaid program and its crowding out of other important priorities has been a major concern for most governors, democrat and republican. As recently as 2012, Montana Governor Brian Schweitzer, a Democrat, told the Washington Post that, "unlike the federal government, Montana can't just print money. We have a budget surplus, and we're going to keep it that way." See N.C. Aizenman and Karen Tumulty, *"*Democrats Share Concerns over Medicaid Expansion*," Washington Post*, July 13, 2012, p. A3.

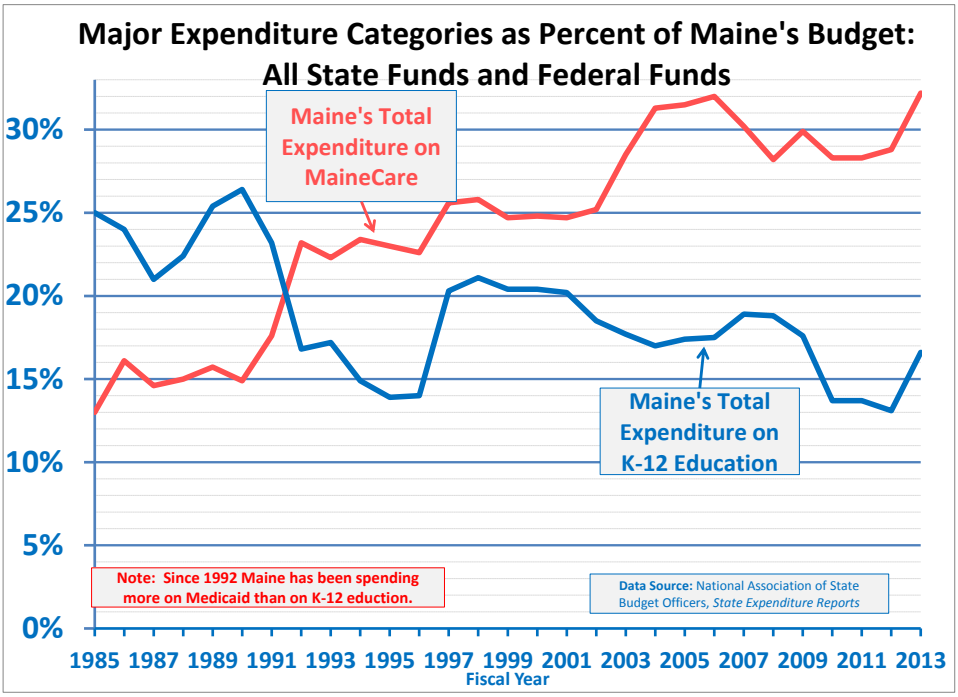

Figure 7: Major Expenditures Categories as Percent of Maine's Budget - All State and Federal Funds

Figure 7 is a chart that compares Maine's spending (includes all funds) to the national average. Maine's spending pattern preceded the national pattern by more than ten years. Medicaid overtook basic education spending as a percentage of the total budget in 1992 for Maine. For State Fiscal Year (SFY) 2012-13, Medicaid spending was 32.2% of the budget, nearly double the 16.6% for basic education.

Using estimated NASBO data showing all funds for SFY 2013, Maine ranks low in basic education expenditures as a percentage of the total state budget and very high in Medicaid expenditures as a percentage of the total state budget compared to other states. (See **Figures 8, 9, and 10**.)[37]

Figure 8 also shows the top five states for each of these categories and provides the rankings for Maine, New Hampshire, and the state average. Vermont spends the most of any state on basic education at 32.5%, followed by Indiana at 31.3%.

SFY 2013 Percentage of Total State Budget			
Education		**Medicaid**	
State and Rank	**%**	**State and Rank**	**%**
1. Vermont	33	1. Missouri	36
2. Indiana	31	2. Pennsylvania	34
3. Georgia	31	**3. Maine**	**32**
4. Minnesota	27	4. Arizona	32
5. Texas	27	5. Indiana	32
13. New Hampshire	**23**	**15. New Hampshire**	26
State average	***19***	***State average***	***23***
31. Maine	**17**		

Figure 8: State Ranks for Spending on Basic Education / Medicaid

[37] National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2011–2013 State Spending.* 2013.

New Hampshire ranks 13th at 23.3%. The state average is 19.4%. Maine ranks 31st at 16.6%. For Medicaid, Maine has the third highest expenditure at 32.2%, after Missouri and Pennsylvania. New Hampshire is 15th at 25.6% and the state average is 22.8%.

Maine ranks low in basic education expenditures as a percentage of the total state budget and very high in Medicaid expenditures as a percentage of the total state budget compared to other states.

The crowding out of state spending for K-12 education, both nationally and state-by-state, may help explain why there have been only marginal gains in educational outcomes since the 1970s, when the upward trend in high-school graduation rates of the 20th century — a pattern that had helped to fuel worker productivity and economic growth — came to a halt. Although Maine, like other states, has experienced an increase in high-school graduation rates since 2005, the recent uptick represents mostly a return to the baseline of 40 years ago. At the same time, Maine has seen significant declines in the mean SAT scores, both reading and math, of college-bound high-school seniors, since the mid-1990s, according to data from the National Assessment of Educational Progress.[38]

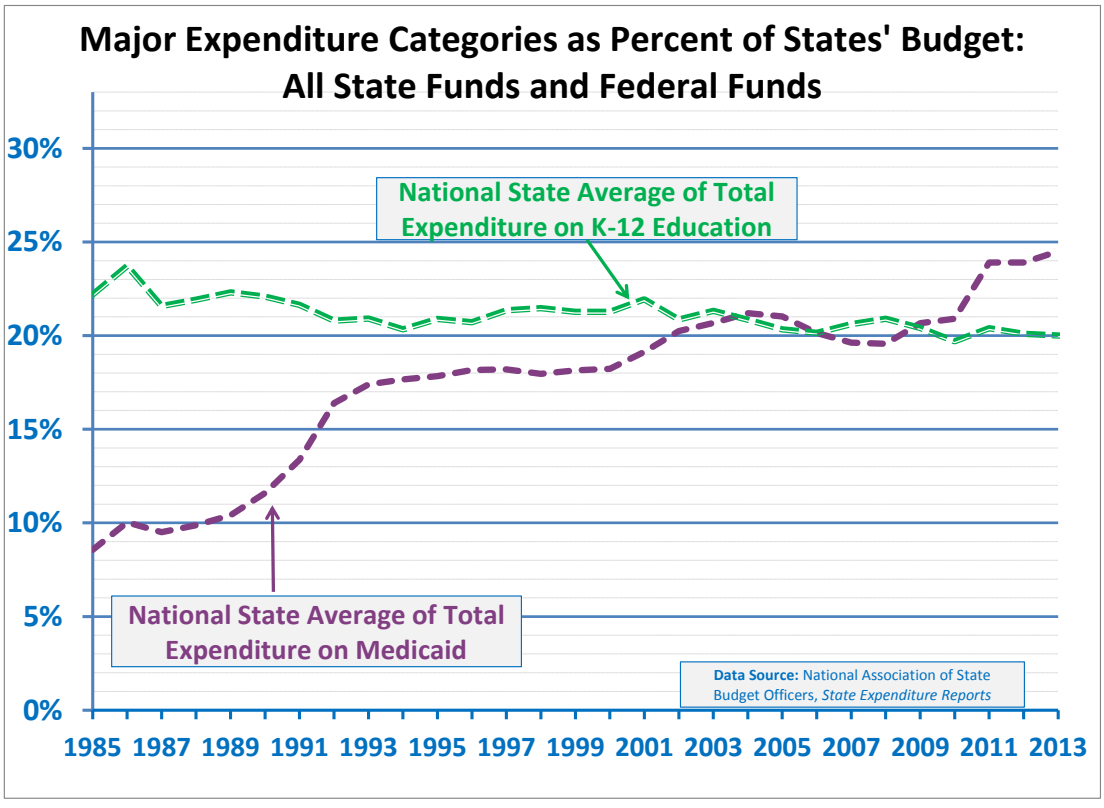

Figure 9: Comparing Maine Total Expenditures on MaineCare and K-12 Education

[38] National Center for Educational Statistics, *Digest of Educational Statistics*, Table 174, accessed at: http://nces.ed.gov/programs/digest/d12/tables/dt12_174.asp.

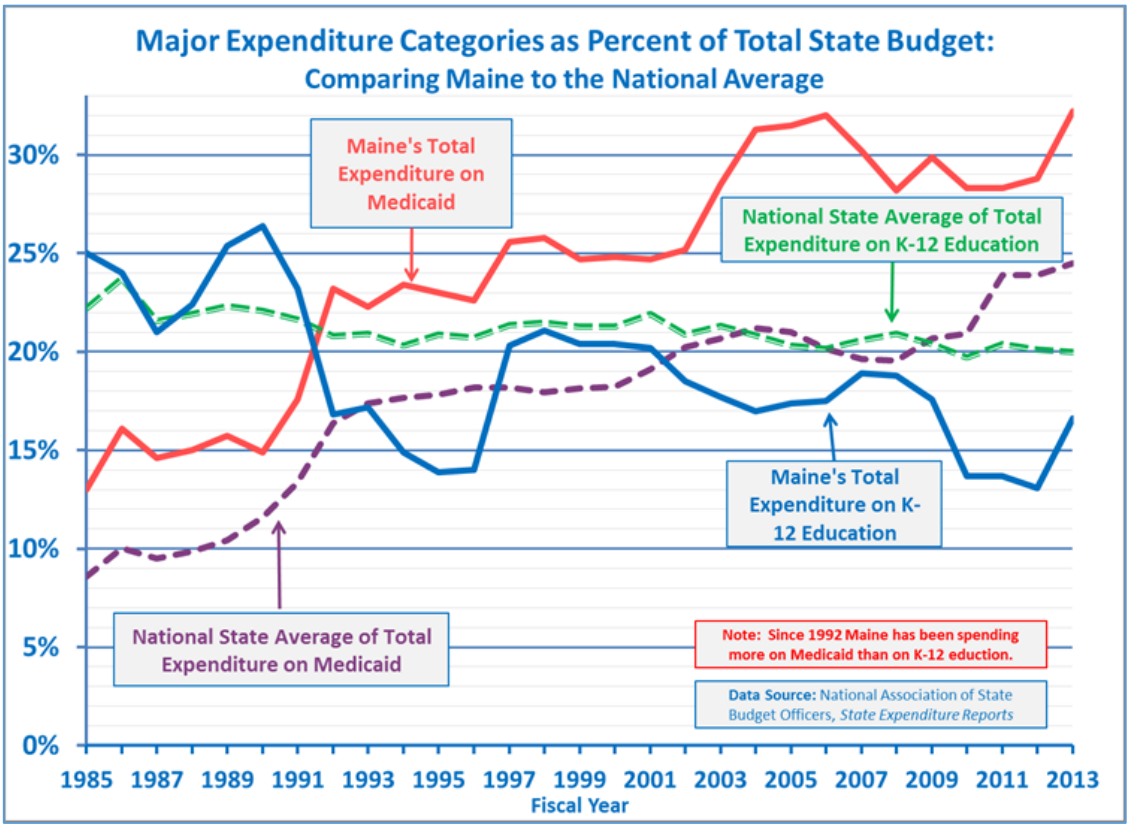

Figure 10: National Average of State Expenditures on Medicaid and K-12 Education

Public safety and corrections are two other priority areas where states are struggling to maintain funding. Decreased budgets for police can result in less crimes being solved, if not higher crime rates, due to reductions in manpower and other resources. Decreased budgets for corrections have not only resulted in reduced staffing, raising safety concerns for correctional officers, but have also forced some states to release prisoners early. For example, the U.S. Supreme Court ruled in May 2011 that California had to reduce its prison population by 32,000 over two years because its overcrowding problem violated the Eighth Amendment to the U.S. Constitution.[39] Yet putting violent offenders back on the street poses clear dangers to the public. While Maine has experienced a decline in rates of "index crime," meaning the most serious and commonly reported crimes, it has nonetheless experienced sharp jumps in rates of rape, domestic violence, and especially drug-related crime. Moreover, offender recidivism rates are rising. According to the Maine Statistical Analysis Center, a function of the University of Southern Maine's Muskie School of Public Service, arrests for drug-abuse violations have increased dramatically in the past 25 years. As a percentage of all arrests in Maine, drug arrests have jumped from more than 4% in 1986 to nearly 11% in 2010.

[39] Brown, Governor of California, *et al. v. Plata et al.*

Less Funds for Vulnerable Populations

Previous caseload expansions and burgeoning costs have also placed a strain on the capacity of the Medicaid programs to serve the most vulnerable populations, as partially evidenced by waiting lists. At a time when a number of states are moving increased numbers of healthy adults of working age onto the Medicaid rolls, a number of state Medicaid programs possess waiting lists for current programs serving the neediest population groups. These services, provided mainly through Section 1915(c) home and community based (HCBS) waivers,[40] generally serve vulnerable populations that require more intense services and supports, such as individuals with intellectual disabilities or the elderly, to avoid institutional care.[41] A 2011 Kaiser Foundation report showed the wait list for Maine's 1915(c) waiver programs to be almost two thousand while other New England States had a lower number of citizens awaiting services. Some other states had no wait lists at the time of the study.[42] Pennsylvania was the closest state geographically with a wait list that exceeded Maine at the time of the study, and there were twenty-two states in the report with wait list populations less than that of Maine.[43] By electing to change the purpose of Medicaid from a program to serve vulnerable populations to one that serves everyone below a fixed income level, "expanding" states seem to be giving little consideration of how to handle the populations that have had to endure waiting lists. These populations represent, in most cases, individuals who cannot be easily served through commercial health plans, unlike the expanded population.

Inadequate Payment to Providers

In addition to the issue of wait lists, many states are concerned about their ability to maintain existing service levels or to provide for those entering the Medicaid program. Maine like all states, struggles to pay physicians adequately. For every dollar that private insurers pay a physician,

[40] The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. See www.Medicaid.gov.

[41] Medicaid is a lifeline for most people with significant disabilities who have greater medical needs and often require assistance with activities of daily living throughout their lifetimes, such as getting dressed, taking medication, preparing meals, and managing money. Medicaid is overwhelmingly the largest funding source of both acute health care and long term services and supports since people with disabilities who are covered by Medicaid generally do not have access to employer based or other private coverage.

[42] According to the Kaiser 2011 State Health Facts on Waiting Lists, due to the limited number of HCBS slots in states, there are over 500,000 people on waiting lists for services, over 300,000 of whom are disabled. The wait can be as long as 8-10 years. This crisis results in unnecessary, unwanted and costly institutional care; family members being forced to quit jobs or take on second jobs to help care for their loved one; and families having to leave their loved ones unattended or in the care of unqualified persons.

[43] For the 2014-2015 biennial budget, the LePage Administration and the state legislature committed $27.3 million in total funds (state and federal) to reduce the waiting list for services for individuals with intellectual disabilities. This included $5.0 million and $5.4 million of general funds in SFY 2014 and SFY 2015, respectively. Even with that commitment, Maine still has 1,328 individuals awaiting services.

MaineCare pays 42 cents on the dollar, the second lowest in New England. (See **Figure 11**.)[44]

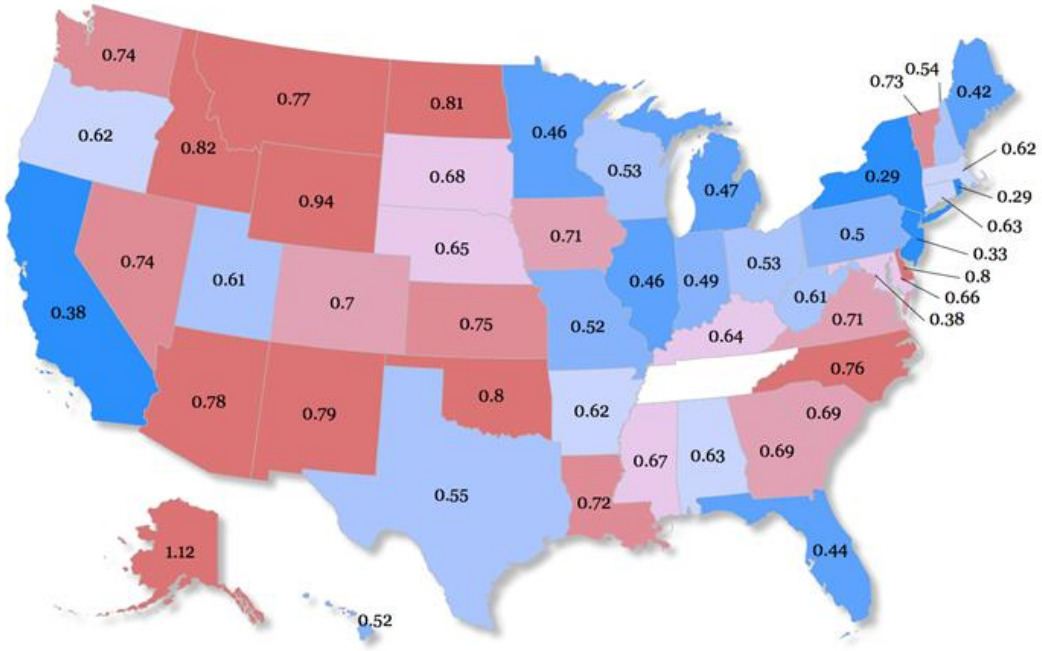

Figure 11: Cents on the Dollar Medicaid Pays Relative to Private Insurers by State

In an attempt to address some of these issues, the ACA required certain changes to provider rate structures. The ACA mandated that Medicaid reimbursement rates to physicians in family Medicaid, general internal medicine, pediatric medicine, and subspecialties who provide primary care services be raised to 100% of Medicare rates but only through calendar year 2014. Other parts of the ACA provide increased funding to safety-net providers that serve low-income individuals and families. This occurred at a time when most states were struggling with revenue slumps due to the recession and because of budget deficiencies were cutting reimbursement rates, not increasing them.

Maine struggles to pay physicians adequately. For every dollar that private insurers pay a physician, MaineCare pays 42 cents on the dollar, the second lowest in New England.

Despite these increases in rates, many reports, including one from the nonpartisan economic and social research group Urban Institute,[45] noted that most states believed that the temporary rate increase would have little effect on attracting new physicians willing to accept new Medicaid patients but believed it would help maintain provider participation in the short term.

The same report noted that the rate increases are estimated to

[44] Avik Roy, "How Do Blue States Expand Medicaid? By Paying Doctors," *Forbes*, accessed December 1, 2013, at: http://www.forbes.com/sites/theapothecary/2012/07/23/how-do-blue-states-expand-medicaid-by-paying-doctors-less/.

[45] Ian Hill, "Will There Be Enough Providers to Meet the Need? Provider Capacity and the ACA," The Urban Institute, November 2012. http://www.urban.org/UploadedPDF/412699-Will-There-Be-Enough-Providers-to-Meet-the-Need.pdf. See also Institute, "Hard Question on Access to Healthcare – Will we have enough Doctors?" Urban http://www.urban.org/issues/hardquestions/accesstohealthcare.cfm, accessed December 10, 2013.

increase provider participation by 11%, which would not be sufficient enough to cover the current existing shortage much less the additional caseloads as a result of mandatory increases.[46] HealthPocket, Inc., released a survey that was conducted on more than 1 million health care professions, noting only 43% were listed as accepting Medicaid. Consequently, while 75% of Maine doctors may be willing to accept new Medicaid patients, another 10% are expected to drop Medicaid patients in the coming months.[47]

The lack of a sufficient number of providers is also affected by policy and regulation. As with many large government agencies, Medicaid's continuously growing bureaucratic and regulatory structure has typically become difficult to manage and is outmoded.[48] States that want to define goals differently from federal standards or try innovative approaches are required to seek federal approval in the form of waivers. The subsequent result for many states has become a cumbersome set of rules and different services (and service definitions) that do not comport or transition across the many operating waivers. They can also be difficult to navigate, manage, and monitor, and most of the time have very little to do with improved overall health outcomes. Unfortunately, because the administration and operation of Medicaid has become so overly burdensome and complex, the very people who the system is supposed to serve can become harmed in the process by receiving inadequate or poor quality care. Additional evidence of the cumbersome structure is demonstrated by the years some states wait to obtain waivers and the inability of the current federal administration to implement several major policy measures of the ACA in January 2013, like issuing guidance on how states were to implement a new coverage option called the "basic health program" aimed at helping low and middle income families who did not qualify for Medicaid gain coverage.

As with many large government agencies, Medicaid's continuously growing bureaucratic and regulatory structure has typically become cumbersome and archaic with a myriad of disparate rules and regulations across populations.

Federal Bias for Institutional Care

Federal Medicaid regulations still favor costly institutional care for individuals with disabilities and the elderly when less expensive community and home-based options would serve these individuals more appropriately. Currently, close to 60% of Medicaid's long term care funding goes to institutional care.[49] This federal bias towards institutional care is due to the fact that nursing home

[46] HealthPocket, "With Expansion Looming, Less than Half of Physicians Accept Medicaid," http://www.healthpocket.com/healthcare-research/infostat/less-than-half-of-physicians-accept-medicaid, accessed December 10, 2013.

[47] Health Affairs, August 2012, vol. 31, no. 8, pp. 1673-1679.

[48] President Obama recently stated in an MSNBC interview with Chris Matthews that "we have these big agencies, some of which are outdated, some of which are not designed properly," accessed at: http://dyn.politico.com/printstory.cfm?uuid=048D0521-3FDE-4793-9939-7BEBAACB1C67.

[49] Strides have been made over the past 15 years to change the institutional bias in Medicaid, however, the labyrinth of burdensome

services are mandatory for states, while HCBS are optional. States currently have two main options to fund HCBS through Medicaid – the HCBS waiver (Section 1915(c)) or the HCBS state plan option (Section 1915(i)). The 1915(c) waiver is only available to individuals who qualify for an *institutional level of care*. Under this waiver, states can cap the number of eligible people, maintain waiting lists, and limit services to certain geographic areas. Additionally, states must apply for renewal of the waiver from Medicaid, which is a burdensome and lengthy process. The 1915(i) state plan option, on the other hand, allows states to have eligibility that is below the institutional level of care before people need nursing home care.[50]

Federal regulations favor costly institutional care when less expensive community and home-based options would serve recipients more appropriately. Close to 60% of Medicaid's long term care funding goes to institutional care.

Maine offers a number of different Medicaid services for HCBS. In addition to mandatory and optional Medicaid State Plan services, there are currently six approved home and community based waivers that serve elders, adults with physical and intellectual disabilities, and children, including one recently received approved specific to adults who have experienced Cerebral Palsy, Seizure Disorders, or other conditions during their first 21 years of life causing significant disabilities (referred to as "Other Related Conditions"). The Maine Department of Health and Human Services (MDHHS) is also currently designing and submitting a waiver to serve individuals with acquired brain injury in future years.[51] Further, MDHHS together with legislative support is in the midst of attempting to remediate and simplify the complex operational long term care system that has been institutionalized in the department over the past 30 years or more. Although the MDHHS has begun to fix the system and with it properly allocate funds across populations to begin addressing the impending aging of the population and the complexities that go along with it, major structural reforms are still necessary to the current enterprise to create fiscal stability and sustainability so that the current and future needs of people with chronic and co-occurring long term support and service needs are met with quality and dignity.

MDHHS together with legislative support is in the midst of attempting to remediate and simplify the complex operational long term care system that has been institutionalized in the department over the past 30 years or more.

federal rules and regulations and the tedious waiver and state plan amendment process have made the undertaking of balancing the system and implementing appropriate care settings inconvenient and administratively burdensome for states.

[50] The Affordable Care Act does provide a new state plan option to provide home and community-based services in Medicaid Section, 1915(k). Also, as of April 2010, the 1915(i) state plan option no longer allows states to cap the number of eligible people, keep waiting lists, and limit services to certain geographic areas. They may target services to certain population groups.

[51] See MDHHS's Balancing Incentive Payment Program Application, May 2013, accessed at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/Maine-BIP.pdf.

Having recently received a grant called the Balancing Incentives Program Grant (BIP), Maine undertook a major initiative that includes the following:

- Working with community partners and stakeholders in a collaborative fashion to achieve the goals of increasing home and community based supports,
- Building upon the supports that Maine currently has in place to create a "No Wrong Door/Single Entry Point" system,
- Developing statewide core standardized assessments, and
- Creating a conflict-free case management system.

This grant will complement other ongoing initiatives in Maine aimed at system reform and rebalancing long-term services and supports (LTSS) towards community living.

Despite the inclusion of these and other incremental changes to MaineCare over the years and the current work of the LePage Administration to bolster home and community based services and balance the system, the federal bias toward institutional care remains. Because MDHHS' operational resources are severely limited, it would seem proper that MaineCare continue to focus on creating and implementing structural reforms, which are designed to offer more appropriate care settings for elderly and vulnerable populations and which will improve the quality of care for all recipients through current and future federal partnerships like BIP, without having the additional burden of taking on new populations via the ACA at the current time.

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Section III: Summary of States' Experience with Expansion

Initial Eligibility Determination Challenges

According to the most recent information available, twenty-two states are not expanding eligibility for Medicaid, three states are currently undecided, and twenty-five states are expanding eligibility in some form or another.

From an operational perspective, states that are relying on a federally administered health care exchange, which includes Maine, are experiencing serious challenges with determining eligibility. The USA Today recently reported that the:

> *"federal health care exchange is incorrectly determining that some people are eligible for Medicaid when they clearly are not, leaving them with little chance to get the subsidized insurance they are entitled to as the Dec. 23 deadline for enrollment approaches. When consumers applying for insurance put their income information into subsidy calculators on HealthCare.gov — the exchange handling insurance sales for 36 states — it tells them how much financial assistance they qualify for or that they are eligible for Medicaid. If it's the latter, consumers aren't able to obtain subsidies toward the insurance, although they could buy full-priced plans."* [52]

".. the federal health care exchange is incorrectly determining that some people are eligible for Medicaid when they clearly are not." *USA TODAY*.

The article also reported that people making as much as $80,000 a year are being told that they qualify for Medicaid on the federal site www.HealthCare.gov.[53]

According to the ACA, regardless of state decisions to expand Medicaid, all states must implement new streamlined eligibility enrollment processes.[54] These processes are designed to align eligibility determinations for Medicaid, CHIP, and premium tax credits in the marketplace. These new systems will use data sharing, drawing from various state and Federal data records, to populate and verify information on Medicaid applications and re-certifications. If executed properly, this will provide states with the ability to make real-time eligibility and enrollment determinations, and mitigate the need for applicants to provide in-person paperwork to

[52] Jayne O'Donnell. "Federal exchange sends unqualified people to Medicaid," *USA Today*, December 9, 2013.

[53] Idem.

[54] Although the federal government is providing time-limited 90% federal funding to support system development, state costs can still be significant depending upon the amount of upgrading necessary. The effectiveness of the new system will depend upon states' ability to implement it successfully. Implementation will demand the following: significant changes to policy; comprehensive enhancements, if not full replacements, of state information technology systems; the making of new application and enrollment materials; the establishment of new outreach methods; the potential reorganization of state eligibility employees; and unprecedented coordination between organizations and entities.

verify information provided to the state on their applications. The challenge for many states is that they do not possess a sophisticated enough system able to handle the type of volume. Maine is included among those states.[55]

Medicaid Realizes Largest Increases with the ACA

States are reporting higher enrollment in Medicaid than in private insurance since the Affordable Care Act exchanges opened October 1, 2013. A new report released by the Centers for Medicare and Medicaid Services on December 3, 2013 reveals that close to 1.5 million people were determined eligible in the month of October to enroll in Medicaid or the Children's Health Insurance Program (CHIP).

States are reporting higher enrollment in Medicaid than in private insurance since the Affordable Care Act exchanges opened October 1, 2013. The growth is more substantial in states that have decided to expand Medicaid.

As one example, in the state of Washington, in the first two months of enrollment, the state's health-care exchange — Healthplanfinder— enrolled 176,468 Washingtonians in coverage. Over 91,000 are newly eligible for expanded Medicaid. More than 65,900 were currently eligible but were not enrolled, which left only 18,000 plus residents who purchased private policies.[56]

The number of applications for Medicaid has increased under the Affordable Care Act, with growth more substantial in states that have decided to expand Medicaid. In states that are not expanding Medicaid, applications to Medicaid and CHIP increased 4.1% in October over the previous few months, and the total number of individuals determined to be eligible for Medicaid or CHIP was 697,019. In expansion states, applications jumped 15.5%, and 757,991 new eligibility determinations were made. The total across all states was an 8.6% increase in applications and 1,460,367 new eligibility determinations.[57]

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[55] Eligibility systems and staff are already enormously burdened. For example Illinois, a state with a sizeable Medicaid program, is just one state that is experiencing problems trying to remove ineligibles from their welfare system rolls. In fact, the early findings of an ongoing review of the Illinois Medicaid program revealed that half the people enrolled were not even eligible. A review of the Illinois Medicaid program confirms massive waste and fraud. A review was ordered more than a year ago-- because of concerns about waste and abuse. So far, the state says reviewers have examined roughly 712,000 people enrolled in Medicaid, and found that 357,000, or about half of them shouldn't have received benefits. After further review, the state decided that the percentage of people who didn't qualify was actually about one out of four. "It says that we've had a system that is dysfunctional. Once people got on the rolls, there wasn't the will or the means to get them off," said (state) Senator Bill Haines of Alton. A state spokesman insists that the percentage of unqualified recipients will continue to drop dramatically as the review continues because the beginning of the process focused on the people that were most likely to be unqualified for those benefits. Ted Dabrowski, Vice-President of The Illinois Policy Institute think tank, spoke with News 4 via SKYPE. He said the Medicaid review found two out of three recipients either got the wrong benefits, or didn't deserve any at all. "We added so many people to Medicaid rolls so quickly, we've lost control of who belongs there," said Dabrowski. But regardless of how it ends, critics say it is proof that Illinois has done a poor job of protecting tax payers' money, adapted from Channel 4 KMOV.com, St. Louis, accessed at: http://www.kmov.com/news/just-posted/Audit-reveals-half-of-people-enrolled-in-IL-Medicaid-program-not-eligible-230586321.html.

[56] Washington Signing Up More People for Medicaid than Private Plans. *Catholic Online*. December 6, 2013.

[57] Centers for Medicare and Medicaid Services. Medicaid and CHIP: October Monthly Applications and Eligibility Determinations,

Selected State Highlights of Recent Activity[58]

Expansion states are already seeing a large number of individuals enrolled in Medicaid. Many of these individuals are prequalified for expanded Medicaid because they are already enrolled in other entitlement programs such as food stamps.[59] For example, in Oregon, 70,000 residents have enrolled as a result of aggressive outreach campaigns to those who receive food stamps in the state. Other states have followed similar advertisement campaigns with varied success.

Arizona: The number of new applications is not available at this time. In total, Arizona expects 57,000 people to qualify for its expanded Medicaid program. In addition, the state expects 240,000 more individuals to enroll in its existing Medicaid program for childless adults with incomes at or below the federal poverty level. Enrollment in that program was frozen in 2012 at 70,000.

Arkansas: Arkansas elected to expand its Medicaid program from 17% of FPL to 138% of FPL.[60] Arkansas has received 70,595 applications for its expanded Medicaid program. Of those, 3,672 came through the state's existing Medicaid website, 1,785 were paper or phone applications, and the rest were positive responses to a mailing to 132,000 households that receive food stamps. Ultimately, the state expects about 250,000 uninsured residents to qualify for Medicaid.[61]

California: Newly eligible enrollment in expanded Medicaid is expected to total about 1.4 million. Of that number, 600,000 people will come from the state's early expansion program approved by the federal government in 2011.

Colorado: Colorado has qualified more than 25,000 adults for its expanded Medicaid program. Of that number, approximately 9,000 were on a waiting list for an existing Medicaid program that covers adults with extremely low incomes. Another 10,000 people enrolled in that program will also be transferred to expanded Medicaid coverage in January. Combined, that comes to 35,000 individuals, more than 20% of the 160,000 uninsured residents Colorado expects to be eligible for its expanded Medicaid program.

December 3, 2013.

58 Most information modified from Pewstates.org information on the states.

59 Expediting the eligibility process does not necessarily translate into program integrity.

60 States like Maine, Massachusetts, and Vermont already possessed expanded populations prior the ACA whereas states like Arkansas did not.

61 Arkansas is one of the first states to use a new tool for facilitating expedited Medicaid enrollment. The state is using information it already had on hand – such as Supplemental Nutritional Assistance Program (SNAP) income data– to conduct an expedited (express) "administrative transfers" to Medicaid. To implement the strategy, Arkansas sent letters to SNAP participants letting them know they are potentially eligible for Medicaid and inviting them to enroll by responding to the letter. To enroll, the person returns a simple form and the state conducts additional data checks, as appropriate. Since the state began sending letters in early September, Arkansas reports that 63,465 individuals have been "fast tracked" into Medicaid with little wait. During the same period of time, the state also found 3,000 unenrolled children who are eligible for ARKids First, the state's Medicaid and CHIP programs. Centers for Medicare and Medicaid Services, Medicaid and CHIP: October Monthly Applications and Eligibility Determinations, December 3, 2013, p. 3.

Connecticut: Connecticut has enrolled 3,550 new people in its expanded Medicaid program through its state-run exchange and Medicaid website. In addition, at least 48,000 enrolled in a state-run low income-health program have already been moved into expanded Medicaid. Connecticut expects a total of 55,000 expanded Medicaid enrollees in 2014.

Delaware: No new enrollment data is available yet. Delaware already provides Medicaid coverage for 30,000 adults with incomes up to the federal poverty level ($11,490). Its expanded Medicaid program is expected to cover another 30,000 people with incomes between $11,490 and 138% of the federal poverty level ($15,856).

District of Columbia: D.C. began expanding its Medicaid program in June 2010. By June 2013, nearly 50,000 new people were enrolled. The District has not estimated how many people will ultimately enroll in expanded Medicaid.

Hawaii: Hawaii has approved 6,100 applications for expanded Medicaid. By 2014, the state expects a total of 54,000 enrollees.

Illinois: The Illinois Medicaid agency has received 30,124 applications for expanded Medicaid through its existing website. Illinois has an exchange partnership with the federal government so applications are also being filed on the federally-run exchange. In addition to online applications, 46,000 people responded to an August mailing to 123,000 food stamp recipients. Illinois has enrolled 26,000 of those respondents and is processing the balance. In addition, 100,000 people in Cook County who participated in a limited early Medicaid expansion enrollment group will automatically be rolled over to the expansion program on January 1, 2014. Projected enrollment is 342,000.

Iowa: No new numbers are available on Medicaid applications. In all, 150,000 uninsured Iowans are expected to qualify under the proposed expansion. About 63,000 residents with incomes up to 200% of the federal poverty level ($22,980) are currently enrolled in a Medicaid health plan with limited benefits. Most are expected to qualify for expanded Medicaid. Iowa has not yet received federal approval for its Medicaid expansion plan, which is similar to Arkansas' so-called private option. Iowa's Medicaid expansion was recently granted partial approval on December 10, 2013.

Kentucky: Kentucky has received 25,654 applications for expanded Medicaid through its state-run exchange. Ultimately, the state expects 308,000 low-income individuals to qualify.

Maryland: The number of applications from its state-run website is not yet available. However, Maryland has an existing, limited-benefit health plan known as Primary Adult Care (PAC) available to all adults with incomes up to 123% of the federal poverty level ($14,133). As of September 30, enrollment in the plan was 82,423. Maryland expects enrollment in PAC to expand to 88,000 by January 1, 2014, when the entire PAC population will automatically convert to full Medicaid benefits. In addition, residents in a narrow income band (124% to 138% of poverty) can sign up for expanded

Medicaid on the state exchange. Overall, Maryland expects 110,000 people to be enrolled by the end of 2014.

Massachusetts: No enrollment numbers are available at this time. As a result of its own health care reforms launched in 2006, Massachusetts has a 97% insured rate. Still, the state expects about 45,000 people to obtain Medicaid coverage as a result of the expansion.

Michigan: No enrollment numbers are available. The Michigan legislature approved Republican Governor Rick Snyder's proposed Medicaid expansion in September but postponed implementation until April 2014.

Minnesota: The federal government granted Minnesota special permission to enroll 84,000 individuals in the expanded Medicaid program in 2011. Another 2,496 newly eligible Medicaid members completed applications on the state-run exchange in the first two weeks of October. Ultimately, Minnesota expects to cover 265,000 adults in its expansion. In addition, it is the only state that has opted to provide a so-called "Basic Health Plan" for people with incomes up to 200% of the federal poverty line ($22,980). Under the ACA, the federal government will pay 85% of the costs starting in 2015. That program is expected to grow to 160,000.

New Hampshire: The Governor called a special session to consider Medicaid Expansion and on November 21, 2013, Special House Bill 1 to expand Medicaid, approved by the House early in the day, was rejected by the Senate. However, spokespersons for both parties have stated that negotiations would continue in the 2014 general session. They expressed interest in considering bills that include provisions to use federal Medicaid funds to buy private insurance for most of the newly-eligible adults as well as a new state-managed care program for other adults.

New Mexico: New Mexico has approved 2,507 applications for expanded Medicaid through the federally operated exchange and its existing Medicaid website. In addition, 100,000 enrollees in two limited-benefit state health care programs will be rolled into the expanded Medicaid. New Mexico expects 130,000 people will be in the expanded program by 2015.

New York: No enrollment numbers are available yet. New York already covers parents with incomes up to 150% of the federal poverty line ($17,235) and childless adults with incomes up to the federal poverty level ($11,490).

North Dakota: The Medicaid agency has received 147 applications for expanded Medicaid. In December, the state plans to send letters to 36,000 households that receive food stamps or home heating assistance, inviting eligible adults to sign up for expanded Medicaid. Total enrollment in expanded Medicaid is expected to reach 32,000.

Ohio: The most recent state to expand Medicaid, Ohio expects to sign up 275,000 newly eligible Medicaid enrollees. Republican Governor John Kasich sidestepped the state legislature and won approval for expansion on October 21, 2013, from an executive branch Controlling Board. The state has not yet begun enrollment. The Medicaid agency says it will announce soon when enrollment will begin.

Oregon: Oregon has approved 70,000 applications for expanded Medicaid. Its state-run website had some initial technical difficulties, but new applications were filed over the phone, in person, and through the mail. The vast majority of enrollments came from a mailing in late September that went to 260,000 residents who either receive food stamps or have children enrolled in Medicaid. The state expects roughly 223,000 adults to be enrolled in its expanded Medicaid program by 2015.

Pennsylvania: As of the writing of this document, Pennsylvania's plan had not formally been crafted. Pennsylvania is planning to submit an 1115 waiver and model its reforms after the Arkansas plan by; increasing access to private market coverage through the *Healthy Pennsylvania* Private Coverage Options for Pennsylvanians 21 years of age or older but under 65 years of age with incomes up to 138% of the Federal Poverty Level (FPL), realigning the existing Medicaid benefit plan designs to provide health coverage based on health care needs, and promoting healthy behaviors and improved health outcomes through a cost sharing design and work search activities.

Rhode Island: Rhode Island has approved 3,213 new applications for its expanded Medicaid program. Another 835 are in progress. Projected enrollment is 23,428.

Vermont: About 1,000 individuals have signed up for Medicaid on Vermont's exchange or by submitting paper applications. In addition, 30,000 adults enrolled in two state-run low-income health plans will be rolled into the expanded Medicaid program. By 2015, Vermont expects enrollment to reach 160,000.

Washington: Through its state-run exchange and Medicaid sites, Washington has signed up 26,336 people. Another 30,000 people enrolled in a low-income health program will be automatically enrolled in expanded Medicaid, bringing the total to 56,336. The state expects 270,000 people to qualify by the end of 2014.

West Virginia: West Virginia has pre-qualified 52,056 residents for its expanded Medicaid program. Projected new enrollment is 63,000.

Section IV: MaineCare Overview

Demographic Impact

Demographic changes are important factors not only for determining enrollment in Medicaid programs but also for estimating the impact on specific programs within Medicaid. This is especially true for the demographic factors of age distribution and poverty.

Muskie School Population Projections[62]

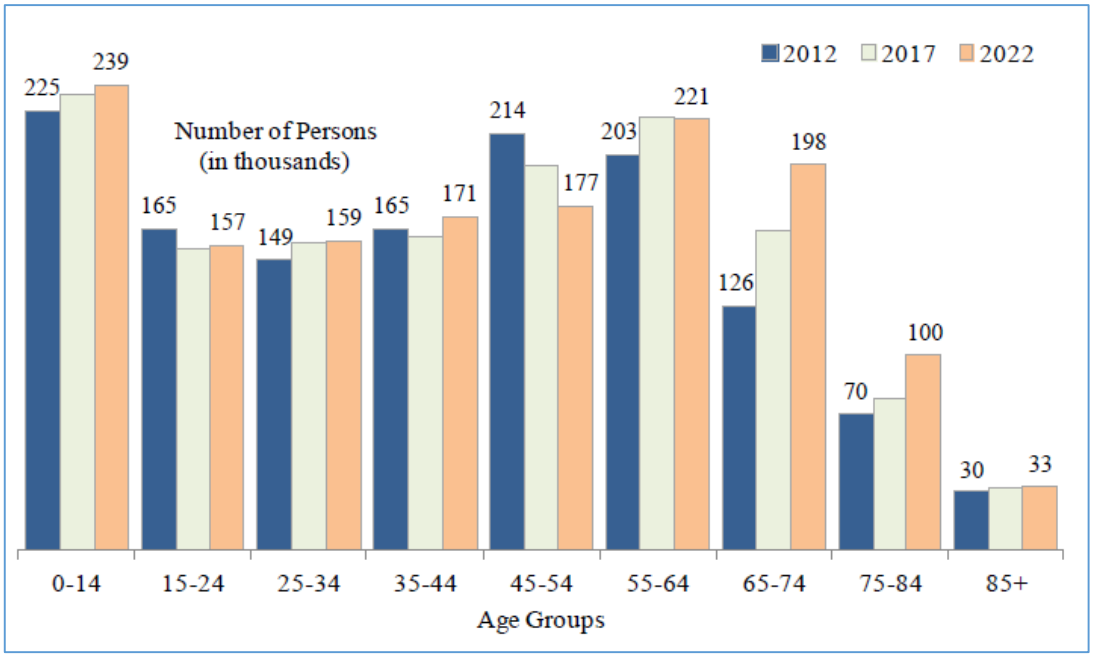

Figure 12: Projected Changes in Maine's Age Profile from 2012 to 2022

In the case of Maine, it has the third most aged populations in the country, and as of 2012, one fifth, or 17%, of Maine's population was age sixty five and older.[63] The Muskie School of Public Service of the University of Southern Maine projects that persons age 65 and older will grow by an estimated 46.5%, faster than any other segment of the population, and it would constitute most of the state's population growth over the next ten years.[64] **Figure 12** shows how the Maine population by age

In the case of Maine, it has the third most aged population in the country, and as of 2012, one fifth, or 17%, of Maine's population was age sixty five and older.

[62] J. Fralich, et. al., "Older Adults and Adults with Disabilities: Population and Service Use Trends in Maine," *Chartbook*, 2012 Edition, Figure 1–2, p. 2. 2012, accessed at: http://muskie.usm.maine.edu/DA/Adults-Disabilities-Maine-Service-Use-Trends-chartbook-2012.pdf

[63] Ibid, pp. 1 and 4.

[64] Idem. Note that the *Chartbook* reported nearly 99% of the state's population growth would be in the age category of 65 and older. Although this calculation is correct when age brackets are aggregated in this manner, it may be misleading by giving the false impression that no category below 65 is projected to have growth when in fact four of those six age categories are projected to have significant growth. The calculation works that way because the age categories of 15-24 and 45-54 are projected to have

category will change through 2022.[65] The demographic distribution of age is an important determinant on Medicaid expenditures whereas older individuals tend to have more chronic illnesses and require more services.

In regard to poverty, Maine recently has had significant growth. According to data from the Small Area Income and Poverty Estimates (SAIPE) of the U.S. Census Bureau, there were 186,484 persons living in poverty, and 51,386 of them were children.

Although Maine's overall population growth has been somewhat slow, growing only 4.2% between the last two decennial censuses for an average annual rate of 0.41%, its poverty level has been increasing dramatically. Children had a poverty rate of 12.9% in 2000 but a poverty rate of 19.8% in 2012. Today one in five children in Maine lives in poverty. The poverty rates are also worsening for the adult population.

Studies indicate that poverty levels directly correlate with low birth weights, which can result in increased infant mortality rates as well as developmental issues in children.

The growth in poverty cannot be fully explained by the last economic recession. In order to reduce the skewing of data due to the impact of economic recessions, two dates were chosen at similar points along the business cycle: 2000 and 2007. These dates are immediately before the peaks of the business cycles. The SAIPE data for 2000 was collected prior to the 2001 recession that began month after the peak of March 2001, and the SAIPE data for 2007 preceded the recession that began the month after the peak of November 2007.[66] However, over that time span, SAIPE data shows the adult population in poverty grew 3.57% annually compared to 0.06% for those adults *not* in poverty. For children in poverty, the annual growth rate was 2.37% compared to negative value of –0.94% for those children *not* in poverty. These trends have serious implications for Maine's welfare programs and significantly impact the outcome of scenarios generated by the financial model discussed in **Section V** of this report.

The growth in poverty is more than simply a fiscal concern. There are no shortages of studies that link poverty to increases in poor health. Studies indicate that poverty levels directly correlate with low birth weights, which can result in increased infant mortality rates as well as developmental issues in children. A study completed by Dr. Barbara Starfield provided evidence that poverty levels have long-term effects. The study noted that when "one birth is of low birth weight and the mother is poor, the likelihood of the next infant being of low birth weight exceeds 40%."[67] The American

negative growth, which negates the growth in the remaining four categories under age 65. Perhaps a better way to represent the growth would be to exclude the two age categories with negative growth, giving the result of approximately 70% of the growth attributed to age category of 65 and older.

[65] Ibid, p. 2.

[66] Dates used for the start of recessions are calculated by the Business Cycle Dating Committee of the National Bureau of Economic Research.

[67] Barbara Starfield, M.D. M.P.H., "Effects of Poverty on Health Status," *Bulletin of the New York Academy of Medicine,* 2012,

Physiological Association found that children living in poverty are at greater risk of behavioral and emotional problems and developing other mental health issues, such as anxiety, depression, and attention deficit/hyperactivity disorders.[68] This study clearly supports why the costs of mental health and neurological disorders are increasing. These two areas of service are MaineCare's top two categories of spending. Information obtained from MDHHS reveal that Mental Health services is the top clinical condition for 95% of MaineCare members and second only to Neurological Disorders.[69]

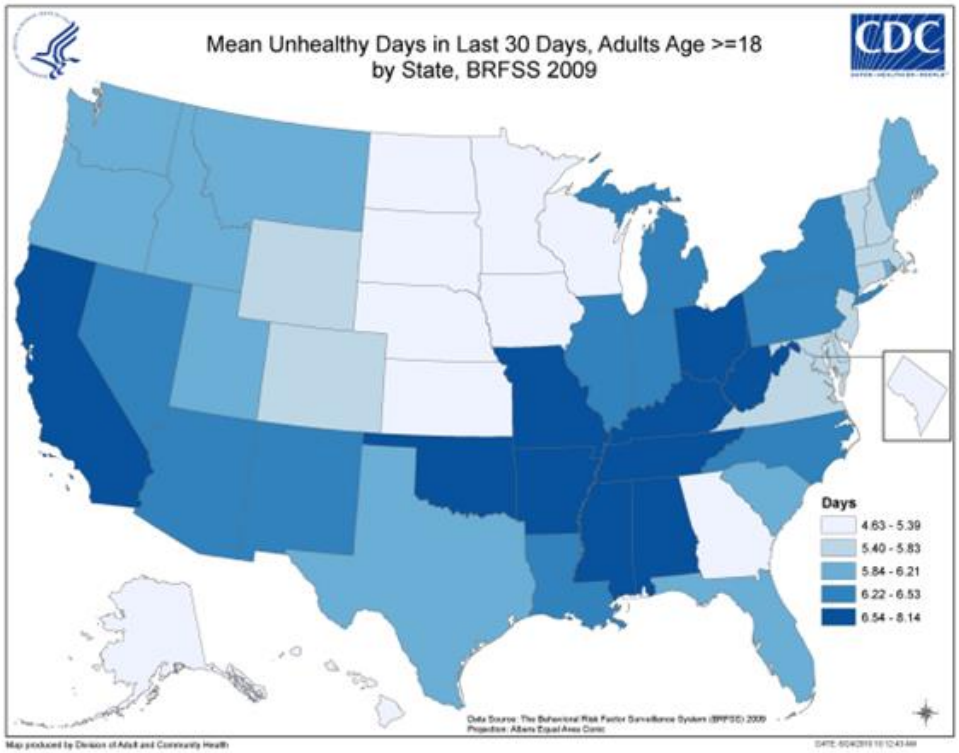

Figure 13: State by State Mean Unhealthy Days in Last 30 Days

Poverty may also be linked to the overall feeling of well-being. The Centers of Disease Control and Prevention (CDC), USDHHS, captures data and reports on health-related quality of life. The CDC has made correlations between well-being, i.e., how healthy a person feels, relative to medical costs. They reported that on average in 2009 Mainers felt unhealthy, either physically or mentally, about six days a month. The CDC also found that younger adults, aged 18-24, suffered the most mental health distress and older adults suffered the most poor physical health and activity limitation. This number increased as the income and education levels of adults dropped. The map in **Figure 13** shows mean unhealthy days for the United States in 2009. These numbers are higher in 2010.[70]

*a*ccessed at: http://www.ncbi.nlm.nih.gov/pmc/issues/142739/a.

[68] Based on information accessed through the American Psychological Association website on the Effects of Poverty, Hunger, and Homelessness on Children and Youth. See http://www.apa.org/pi/families/poverty.aspx.

[69] Idem.

[70] Centers for Disease Control and Prevention, Health-Related Quality of Life (HRQOL). "Figure 2: Mean number of reported

MaineCare Budgetary Overview

According to data provided by MDHHS, MaineCare spending in total funds, including federal funds, for both services and administrative costs was $2.7 billion in SFY 2012-13, accounting for a total of 79% of the total MDHHS agency budget. (See **Figure 14**.)

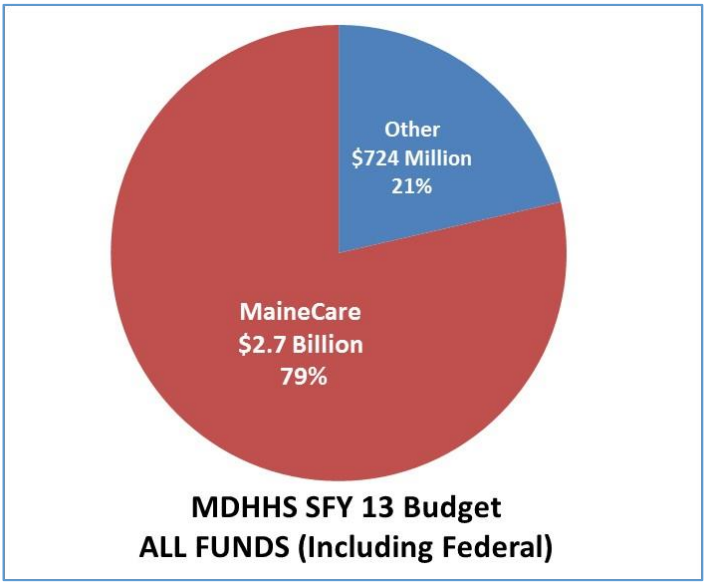

Figure 14: Maine DHHS Budget—General Fund Only

For the General Fund only, MaineCare was $788 million or 73% of the department's General Fund budget. (See **Figure 15**.)

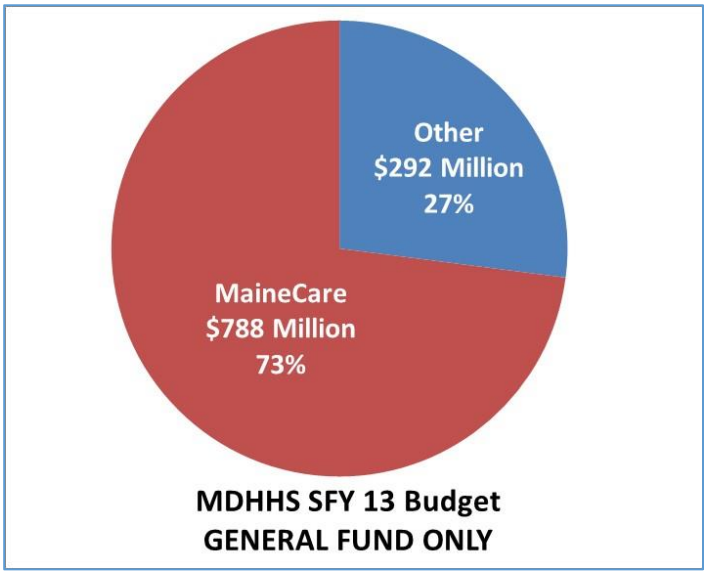

Figure 15: MaineCare as Percent of Funding Source

physically unhealthy days in the past 30 days by state," accessed at: http://www.cdc.gov/hrqol/data/maps/figure2-meanphysicallyunhealthy.htm.

In addition to receiving funding from the General Fund and the federal government, MaineCare also receives revenue in excess of $250 million from the other special revenue sources, which includes the following:

- The Medical Care Services Tax Account
- The Medical Care Hospital Tax Account
- The Nursing Facilities Tax Account
- The Fund for a Healthy Maine

MaineCare Services continue to comprise significant proportions of state revenue sources. For SFY 2012-13, 24.2% of the General Fund was expended on MaineCare Services; 19.0% of all state funds, including the Highway Fund and other special revenue funds, were expended on MaineCare; 59.2% of all federal funds received by the state government were dedicated to MaineCare Services; and, 32.2% of the total of all funds spent were expended on MaineCare Services. (See **Figure 16**.)

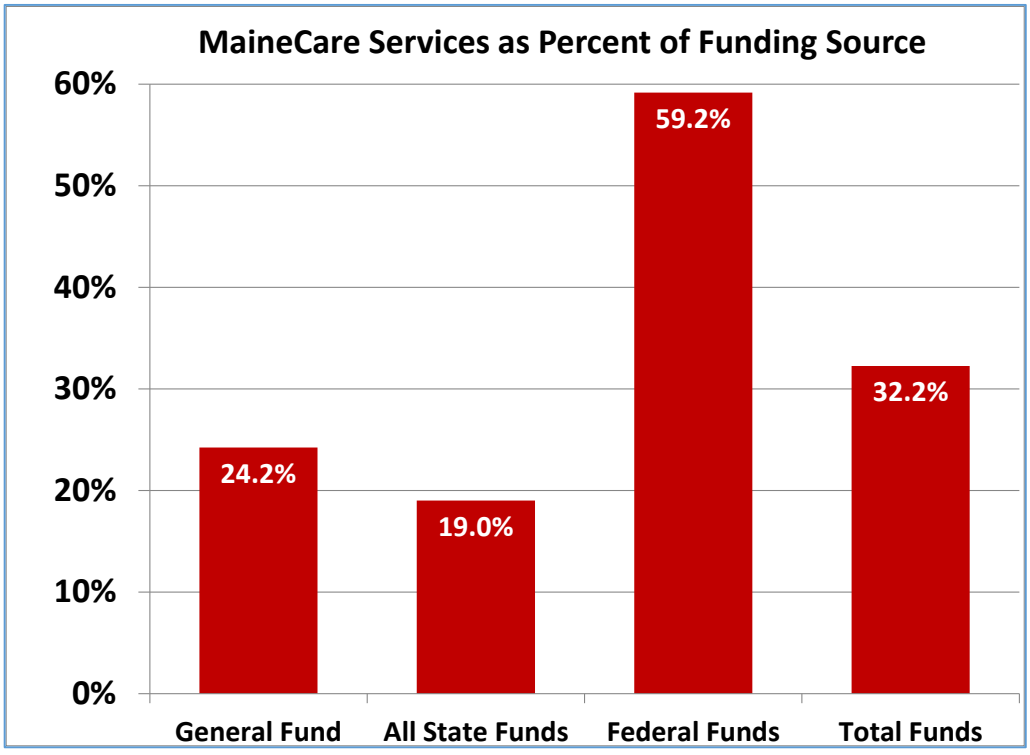

Figure 16: Maine DHHS Budget—All Funds

In total dollars spent, MaineCare is the largest budget item. When focusing on just the General Fund, elementary and secondary education is the largest budget item. However, when the other special revenue funds are added to the General Fund, it adds another $255 million in state funds to support MaineCare, bringing the MaineCare state cost within ten percent of the total elementary and secondary education budget. When federal funds are included, MaineCare spends $1.93 for every dollar spent on elementary and secondary education. (See **Figure 17**.)

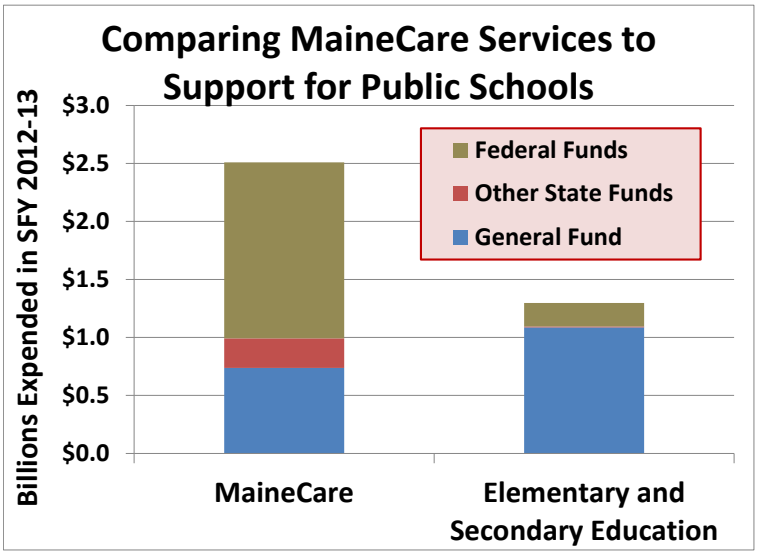

Figure 17: Comparing MaineCare to Public Schools Support

In SFY 2012-13 if federal funds are included, the two largest budgetary items are MaineCare at 32.2% of all funding and elementary and secondary education accounting for 16.7%.

As a percent of total budgetary funds (all state funds and federal funds), the two largest budgetary items comprise 35.7% (elementary and secondary education) and 24.2% (MaineCare) of the General Fund, leaving only 40.1% of the General Fund for all remaining government functions that need to be funded from the General Fund. (See **Figure 18**). When the Highway Fund and other special revenue funds are included, the two largest budgetary items comprise 21.0% and 19.0%, respectively, leaving only 60.0% for all other government functions. When federal funds are added, then the two largest budgetary items switch places, with MaineCare accounting for 32.2% of all funding and elementary and secondary education accounting for 16.7%.

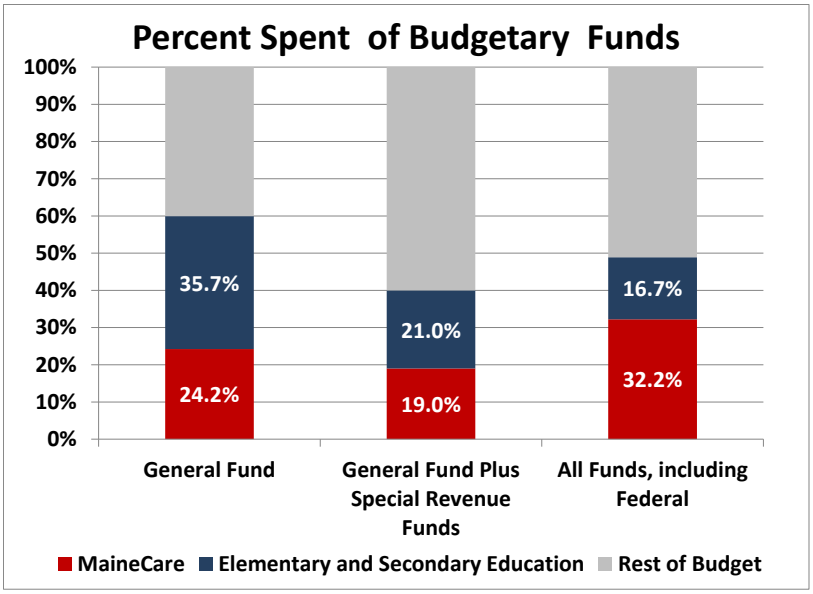

Figure 18: Percent Spent of Budgetary Funds

Compared to other New England states, Maine spends more of its total budget on Medicaid.

Maine's level of Medicaid expenditures are high relative to what other states are spending, Maine spends more of its total budget on Medicaid. (See **Figure 19**.)[71]

Medicaid Expenditures as a Percent of Total Expenditures (NASBO 2013)	
State	**Percent**
Maine	32.2
Vermont	28.0
New Hampshire	25.6
Rhode Island	24.4
Connecticut	22.0
Massachusetts	21.3

Figure 19: New England States' Expenditures on Medicaid - Percent of Total

Over the past ten years, state funds supporting MaineCare services have grown more rapidly than growth in Federal expenditures supporting MaineCare. Average annual expenditure growth for MaineCare Services has been nearly triple the rest of the budget. For the General Fund, MaineCare Services grew over the past ten years at an average rate of 3.7%, compared to only 1.3% for the rest of the General Fund budget. (See **Figure 20.)**[72] For all state funds, the growth rate for MaineCare Services was 6.0% compared to 2.2% for the rest of the state budget. For federal funds, it was only 2.6% growth for MaineCare Services, compared to 2.5% growth for the rest of the budget. In total, including all funds, the growth rate for MaineCare services was 3.8% compared to 2.2% for the rest of the budget.

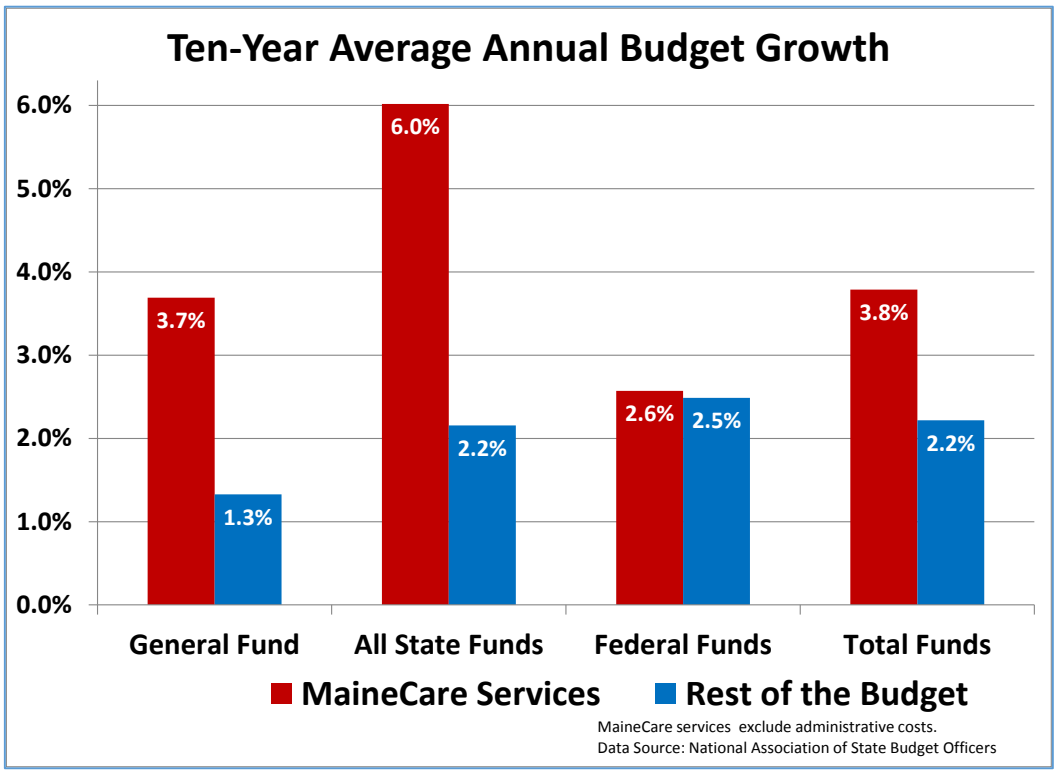

Figure 20: Ten Year Annual Budget Growth Comparisons

[71] National Association of State Budget Officers, "State Expenditure Report: Examining Fiscal 2011–2013 State Spending," 2013. Also, as already presented earlier in this report, Maine has the third highest spending on Medicaid in the nation.

[72] Idem.

Federal Medical Assistance Percentage (FMAP)

The FMAP rate is the mechanism used by the federal government to assist states in funding their Medicaid program. Section 1905(b) of the Social Security Act specifies a formula for calculating the federal assistance percentages. The formula takes into account the average per capita income for each state relative to the national average. By law, FMAP rates cannot be less than fifty percent.[73] The federal government has used enhanced federal assistance percentages or increases to a state base rate to assist the state in offsetting the budgetary demand for public welfare, but in recent history due to its own budgetary demands, the federal government has reduced and eliminated many enhanced match rates and lowered many states base rates.[74]

For example, in Maine, FMAP rates have declined since 2000. A slight increase in 2010 was due to additional federal funding available in the fourth quarter and not an actual long-term increase in the state's FMAP rate. Each percentage-point drop in the FMAP rate results in approximately $25 million in reduced federal participation, which must be made up with funds from the state's revenue base. It is anticipated that states will again see a reduction in FMAP rates as fiscal problems continue to plague the federal government. This position is also backed with evidence that shows declining FMAP rates over past years, despite economic conditions.

In Maine, FMAP rates have declined since 2000. Each percentage-point drop in the FMAP rate results in approximately $25 million in reduced federal participation, which must be made up with funds from the state's revenue base.

[73] United States Assistant Secretary for Planning and Evaluation (ASPE) and United States Department of Health and Human Services Federal Medicaid Assistance Percentages or Federal Financial Participation in State Assistance Expenditures FMAP, Accessed at http://aspe.hhs.gov/health/fmap.htm

[74] During the federal debt ceiling debate in late 2011, the Obama administration issued a plan to cut $100 billion from federal Medicaid spending over the next decade by changing and replacing the traditional Federal Medical Assistance Percentages (FMAP) (and other funding formulas) to the states that determine how many federal dollars states get for Medicaid into a "blended rate" that would simplify the way federal money is divvied among the states. The blended-rate proposal would replace this mix of matching rates with a single (blended) matching rate for each state, which would apparently apply to all of a state's Medicaid and CHIP expenditures, outside of administrative costs. This new formula would shift a greater share of Medicaid spending to the states. The blended rate would be set significantly below the combined effect of the various federal matching rates a state would otherwise receive (in essence a cut). The Obama Administration estimated that this package of changes would save $14.9 billion over 10 years starting in 2017. The federal government would pay a lower percentage of overall Medicaid and Children's Health Insurance Program (CHIP) costs than under current law, and states would bear a greater share. Although this proposal is said to have been "tabled" for further study, the concept caught the attention of federal deficit reducers and could be "dusted off" for use in the near future. Certain policymakers also believe that reductions in federal matching assistance will deter expansions to health care access. Health Affairs: Health Policy Brief, January 12, 2012.

Calculations done using the blended rate formula as early as a year ago, had the State of Maine losing close to $700 million dollars between 2014 and 2022 from projected spending under the ACA FMAP formula. Drew Gonshorowski, "Medicaid Expansion Will Become More Costly to States," *Heritage* Issue Brief No. 3709. August 30, 2012.

Figure 21 shows the trend line of FMAP, SCHIP FMAP, and ARRA FMAP. SCHIP FMAP is the State Children's Health Insurance Program, and rates are set under Title XXI for certain children of expenditures for medical assistance described in portions of the Social Security Act. The rate is an enhanced rate established through a formula established in Section 2105(b) of the Social Security act and is calculated based upon the states base rate and a percent difference between that number and one hundred. However, no state may have a rate that exceeds eighty-five percent. The ARRA FMAP was temporary additional funding from the American Recovery and Reinvestment Act of 2009 to help states with revenue shortfalls and increased caseload due to the 2007-to-2009 recession. Each state qualified for the FMAP increases based upon three separate areas: a hold-harmless amount, a set 6.2% increase, and an increase related to unemployment.[75]

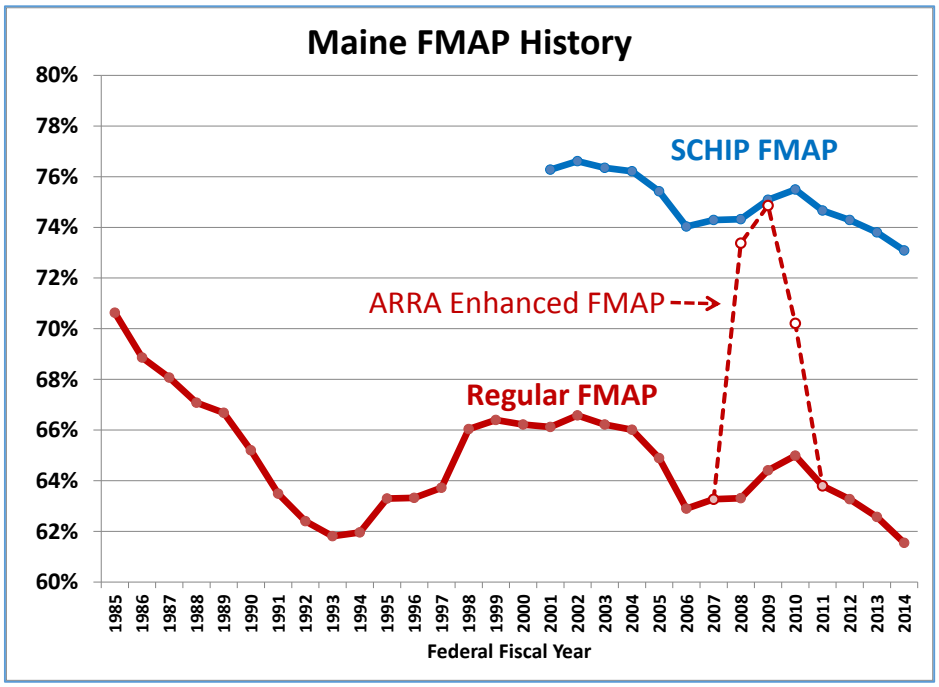

Figure 21: The History of FMAP in Maine

Maine Private Health Insurance Premium Program (PHIP)

States have pursued a number of strategies to leverage funding and stretch their health-care dollars in order to avoid cutting eligibility for families. Authorized under Section 1906 of the Social Security Act, Health Insurance Premium Payment (HIPP) programs subsidize enrollment in employer-sponsored private health insurance for Medicaid-eligible individuals—and their families—who have access to such coverage and for whom it is cost-effective. When an adult is identified as having other private insurance coverage the member's commercial insurance or employer-sponsored insurance (ESI) becomes primary and Medicaid fee-for-service is secondary.

[75] See "ARRA - Medicaid FMAP Increase Provisions" available from the National Conference of State Legislatures, accessed at: http://www.ncsl.org/print/statefed/ARRA-MedicaidFMAPIncreaseProvisions.pdf.

PHIP created in 1993 is MaineCare's Private Health Insurance Payment Program. Enrollment in PHIP is currently voluntary in Maine. To identify MaineCare members who are working that may have access to employer-sponsored insurance (ESI), PHIP Benefit program administrators send letters to MaineCare enrollees that are employed for 32 hours or more per week (approximately 13,000 households) and distribute brochures at regional intake offices and other locations. (See **Figure 22**.) However, unlike the Rhode Island, Iowa, and Pennsylvania programs, the Maine PHIP program has shown low enrollment and minimal cost-savings.

Medicaid Health Insurance Premium Programs (HIPP)		
State	**Program Start**	**Percent of Families Enrolled in HIPP**
Maine	1993	Less than 1 percent
Rhode Island	2001	6
Iowa	1991	1.6
Pennsylvania	1994	1.9

Figure 22: Percent of Families Enrolled in HIPP

Currently, 400 MaineCare households and 1,345 individuals representing less than one percent of total MaineCare working age families participate in PHIP. Rhode Island, in particular, began with low enrollment under a voluntary program but was able to reach more than 6% of cases when enrollment in HIPP was mandated. MaineCare requires members to contact the PHIP administrator in order to be enrolled. Rhode Island also passed legislation to require Medicaid Providers to submit information on employer-sponsored health insurance (ESI) as a condition for enrollment. In addition, all other employers were required to submit timely filings on ESI (RIGL 40-6-9.1).

Initial Issues with Quality

In **Section II** of this report, a number of quality issues with Medicaid in general were highlighted. The process of evaluating Maine's performance measures is ongoing; however, a number of performance measures have been examined in several areas. Consistent with national studies, two areas that surfaced immediately within MaineCare were readmission rates and waitlists for waiver services. Both issues tend to have similar demographics; they both tend to be older adults with multiple chronic conditions whose care is uncoordinated.

Two areas that surfaced immediately for waiver services are:

1. Readmission rates
2. Waitlists

Maine readmission rates within 30 days for persons in many areas exceeded the national average. (See **Figure 23**.) Readmission is defined as a secondary admission for the same admitting diagnosis within a thirty day period.[76] MaineCare has attempted to curb these trends through an existing policy. Currently MaineCare does not reimburse for readmission within 72 hours and will be extending this period to 14 days based on recommendations from the MaineCare Redesign Task Force.[77]

[76] MaineCare Redesign Task Force Recommendation Report, December 2012.

[77] Idem.

In addition to high readmission rates, there is the issue of the large waiting lists to get into specific programs within MaineCare. To be clear, these waiting lists are for persons who are already members of MaineCare but are waiting for services more appropriate to their needs. As of September 2013, MaineCare had waiting lists for these services of approximately 3,100 members, according to the Office of Aging and Disability Services (OADS). These individuals are often some of the most vulnerable citizens and include the elderly, individuals with disabilities, and persons with development disabilities. These citizens have experienced wait times of over two years in some cases in order to be placed for services that include state-funded home based care, assessment, and homemakers services. They are generally low-income families who have no other alternative for medical and behavioral-health services and for which resources will likely be unavailable when ACA expansion is adopted. Complicating the matter of the waitlists are the numerous number of programs operated in order to effectively provide service to Mainers. Maine currently has eight of these programs with waitlists.

Maine currently has eight programs with waitlists for the most vulnerable populations.

Hospital Readmissions within 30 days		
	Maine Rate	U.S. Rate
Pregnancy, Childbirth	7.0%	3.8%
Mental Health	21.5%	11.8%
Circulatory	21.5%	10.4%
Respiratory	22.4%	11.4%
Digestive	22.6%	10.3%
Alcohol/Drug Use	21.1%	13.0%
Musculoskeletal	10.8%	8.3%
Nervous	17.1%	9.5%
Liver, Pancreas	25.5%	12.3%
Metabolic	20.2%	10.7%
Skin, Breast	17.4%	8.0%
Infections	27.4%	11.5%
Kidney	23.9%	12.4%
Injuries, Poisonings	16.8%	8.4%
Health Status	18.6%	9.9%
Female Reproductive	6.4%	6.4%
Ear, Nose, Mouth & Throat	12.6%	7.2%
Myeloproliferative Diseases	49.7%	37.4%
Blood	36.4%	14.1%
Male Reproductive	12.8%	7.2%
HIV Infections	24.4%	17.2%
Multiple Trauma	10.5%	7.9%
Eye	40.9%	6.9%
Burns	5.9%	6.1%
TOTAL	**17.7%**	**9.4%**

Source: Table 16 (Maine Hospital Readmissions within 30 days), *MaineCare Redesign Task Force Recommendation Report*, December 2012, pp. 26-27.

Figure 23: Maine Readmission Rates by Medical Area

	Waitlist (As of 11/1/13)	Average PP Annual Cost (State Funds only)	Annual State Cost to Fund	Annual State & Federal Cost to Fund
State-Funded Programs:				
Consumer-directed Home Based Care	23	$18,900	$434,700	
Home Based Care	210	$8,856	$1,859,760	
Home Based Care Assessment Waitlist	444	$8,856	$3,932,064	
Homemaker (Independent Support Services)	1832	$1,428	$2,616,096	
Annual State-Funded Program Needs Totals	**2,509**		$8,842,620	$8,842,620
MaineCare Programs:				
Section 21, Home and Community Based Services Comprehensive Waiver	850	$101,000	$33,009,325	$85,850,000
Section 29, Home and Community Based Waiver Support Waiver	478	$22,000	$4,043,402	$10,516,000
Physically Disabled Waiver	73	$27,719	$778,034	$2,023,487
Brain Injury Residential Services	21	$95,695	$772,689	$2,009,595
Annual Maine Care Totals (State Funds only)	**1,401**		$38,603,450	
Total State Funding Needed			**$47,446,070**	
Total State & Federal				**$109,241,702**

Figure 24: State and MaineCare Program Waitlists

Figure 24[78] highlights both waiver services for individuals with intellectual disabilities, physical disabilities and brain injuries along with state-only home-based services, the number of persons awaiting services, and the average costs to operate these programs. The chart indicates total waitlists for all programs to be slightly more than 3,900. This number is larger than the actual waitlist total of 3,100 due to the allowance for enrollment in more than one program. All programs listed offer a range of services that include personal assistance in the home with activities for daily living such as bathing, dressing, meal preparation, and basic housekeeping. Additional services include inpatient costs at nursing facilities and other residential care services.

[78] Mary Mahew, "The MaineCare Program Right Size, Right Service, Right Priorities," Table comes from MDHHS presentation, Fall 2013, slide 19.

Muskie School Estimates of Average Age of Long-Term Care Users by Setting for SFY 2010[79]

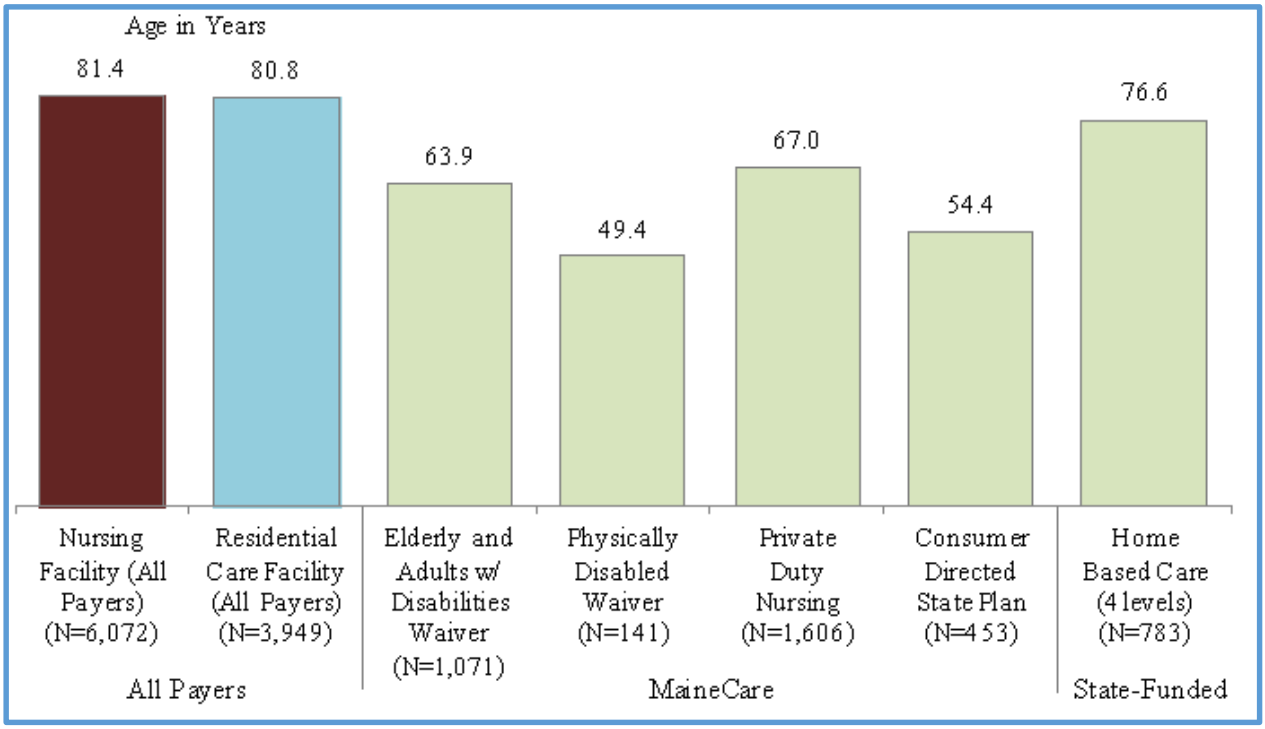

Figure 25: Age by LTC Facility Statistics

The number of MaineCare members using long-term care services is a significant cost factor that needs to be considered. The bar chart was published by the Muskie School of Public Service and **Figure 25** depicts the average age of long-term care uses by setting for SFY 2010.

A worsening economy, an aging workforce and population, rising costs in health care, and increases in poverty levels will without doubt increase the utilization of current MaineCare services.

[79] Muskie School Chartbook, Figure 5-1, p. 18.

MaineCare Enrollment and Per Member Per Month (PMPM) Costs				
Category	SFY 2011-12		SFY 2012-13	
	Members	PMPM	Members	PMPM
Traditional MaineCare				
Aged	22,932	$1,472	22,778	$1,527
Blind or Disabled	51,806	$1,579	52,015	$1,553
Children <100% FPL	110,732	$312	107,312	$321
Parents <100% FPL	50,494	$392	48,848	$392
Pregnancy	1,895	$887	1,922	$912
State Only	1,689	$2,226	767	$1,786
Other Traditional	10,889	$267	12,754	$254
Total Traditional MaineCare	**250,438**	**$711**	**246,397**	**$712**
Other Groups				
Childless Adult Waiver	16,086	$458	10,689	$514
Children > 100% FPL	16,363	$214	14,178	$222
Parents (100%-150% FPL)	22,157	$280	19,702	$271
Total Other	**54,607**	**$312**	**44,569**	**$314**
Grand Totals	**305,045**	**$639**	**290,965**	**$651**

Figure 26: MaineCare Enrollment—Total Members and PMPM

Figure 26 shows the various categories qualifying for MaineCare. These categories fall into one of two groups: traditional Medicaid and "other." Categories under traditional Medicaid are mostly groups that states are mandated to cover to qualify for FMAP funding. Categories under "other" Medicaid groups are optional groups resulting from choices made by the state. The table shows per member per month (PMPM) costs for each MaineCare category.

Policy Changes on the Uninsured and Uncompensated Care

Since 1998, Maine has adopted a number of policies in an attempt to reduce the number of people without health insurance and curb uncompensated care costs.[80] In 2002, Maine applied for and received a Section 1115(a) demonstration waiver that allowed childless adults with income at or below 100% of FPL to receive a comprehensive benefit package. The Centers for Medicare and Medicaid (CMS) allowed the state to tap unused disproportionate share hospital (DSH) allotments to make up the federal share of its waiver. Previously, a portion of the DSH allocation had been

[80] The American Hospital Association defines uncompensated care as follows: "Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's 'bad debt' and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided; this happens when patients are unable to pay their bills, but do not apply for charity care, or are unwilling to pay their bills. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare. Hospital Care Cost," *American Hospital Association Fact Sheet on Uncompensated Care*, December 2010.

divided up among psychiatric hospitals and community hospitals, neither of which traditionally met their DSH limit. The DSH allocation, currently at $85 million (state and federal) became the upper limit for the program. In the waiver proposal, the state estimated that 11,000 new members would enroll in the first year. However, by October 2003, fourteen months after implementation – 16,854 newly eligible childless adults had enrolled in MaineCare.

Even with expansions of public programs over the years, Maine's percentage of uninsured residents under age 65 has remained fairly constant on an annual basis.

Due to the subsequent State budget shortfalls and the risk of exceeding the waiver cost neutrality terms, Maine requested to amend the waiver by reducing the current demonstration benefit package and eliminating retroactive coverage for demonstration populations. These amendments were approved on September 6, 2005 shortly after enrollment was temporarily capped. Subsequently, enrollment caps were used to control spending and by 2013, the cap reduced the program's spending to approximately $40 million in combined annual federal and state spending. As of September 2013, there were less than 8,500 enrolled childless adults. The waiver to cover these individuals expired on December 31, 2013.[81]

While these policies did result in small and temporary decreases in the number of uninsured citizens, it proved not to be a long-term solution in reducing the number of uninsured citizens, which has remained fairly constant on an annual basis as a percentage of all individuals under 65 years of age, as can be seen in **Figure 27.** Over the same period of time, from SFY 1999-2000 to SFY 2012-13, the total MaineCare budget, including both state and federal funds, rose from $1.2 billion to almost $2.5 billion, an increase of 109%. In terms of state funds, the increase was even greater. It grew from $403 million to $992 million, an increase of 146%.

Maine Insurance Coverage for Individuals under 65 Years Old Percent Uninsured								
2003	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
12	10	12	11	10	12	12	11	11

US Census Bureau

Figure 27: Maine Uninsured Rates

Maine's experience in expanding eligibility for MaineCare did not result in a noticeable reduction in uncompensated care. Latest estimates by the Maine Hospital Association place charity care at approximately $200 million. Just like enrollment and the MaineCare budget, hospital charity care also exceeded budget targets as it grew by more than 200% from 2000 to 2013. As these numbers clearly indicate, despite efforts to expand health coverage in order to reduce the number of uninsured citizens and curb uncompensated care, both issues remain unsolved.

[81] Center for Medicare and Medicaid Services, Waiver Information, accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-childless-adults-fs.pdf.

This lack of evidence linking Medicaid eligibility expansions with reductions in uncompensated care costs may be explained by the results of several studies, including one by Jonathan Gruber and Simon Kosali, (2007).[82]

As the study found:

> *"continued interest in public insurance expansions as a means of covering the uninsured highlights the importance of estimates of 'crowd-out,' or the extent to which such expansions reduce private insurance coverage. Our results clearly show that crowd-out is significant; the central tendency in our results is a crowd-out rate of about 60%."*

Recent evidence from employer-sponsored insurance (ESI) in Maine would support that research. From 2000 to 2011, ESI coverage in Maine for the under-65 population fell from 69.6 to 61.3%.[83]

[82] Jonathan Gruber and Simon Kosali. "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau Economic Research, January 2007. The continued interest in public insurance expansions as a means of covering the uninsured highlights the importance of estimates of "crowd-out", or the extent to which such expansions reduce private insurance coverage. Ten years ago, Cutler and Gruber (1996) suggested that such crowd-out might be quite large, but much subsequent research has questioned this conclusion. "We revisit this issue by using improved data and incorporating the research approaches that have led to varying estimates. We focus in particular on the public insurance expansions of the 1996–2002 period. Our results clearly show that crowd-out is significant; the central tendency in our results is a crowd-out rate of about 60%."

[83] Elise Gould, "Employer-Sponsored Health Insurance Coverage Continues to Decline in a New Decade., *EPI Briefing Paper #353*, Economic Policy Institute, December 5, 2012.

Section V: Results of the Financial Model

Overview of Financial Model

The Alexander Group developed and customized a financial model to forecast enrollment and the associated fiscal costs of MaineCare. Various scenarios assuming current trends were run to help Maine policymakers understand potential costs if Maine were to decide to expand eligibility for MaineCare pursuant to the ACA that the U.S. Supreme Court ruled is optional for the states.

The first step in any financial model is to establish a baseline, without which there would be no basis for knowing what the additional cost of a proposal would be. The second step is to incorporate changes to the baseline to include a test case, i.e., a proposal being considered. The third step is to compare the scenarios and evaluate the differences between the test case and the baseline.

The **Baseline** is a forecast of how the MaineCare will track in the future without expansion and assuming pending changes to MaineCare as approved by the Centers for Medicare and Medicaid Services (CMS) of USDHHS. Although MaineCare previously allowed enrollment of parents up through 138% of FPL, beginning on January 1, 2014, MaineCare only allows enrollment up to 100% of FPL. Also beginning on January 1, 2014, the Childless Adults Waiver expired. Although this waiver allowed coverage for childless adults up to 100% of FPL, and as explained earlier in this report, enrollment in the waiver was capped for budgetary reasons. It is important to differentiate the Baseline of the financial model from any baselines established for purposes of Maine's biennial budget.

The Scenarios

The **Baseline** assumes two MaineCare programs are discontinued: (1) parents 101% to 138% of FPL, and (2) the Childless Adult Waiver.

The **Expansion Scenario** assumes allowing everyone at 138% of FPL to be eligible for MaineCare.

For this analysis, the test case being evaluated is that Maine would expand eligibility of MaineCare to allow enrollment of all individuals determined to have income equal to or less than 138% of FPL. This test case is called the **Expansion Scenario**. The financial model assumes an effective date of July 1, 2014, for implementation of the expansion.

The Baseline and the Expansion scenarios presented in this section are based on current-trend analysis that assumes the determining factors will continue their current trajectory; i.e., the values chosen for these factors are in the middle of a possible range of options. As with all forecasts, there are risks that these scenarios will not be realized and the actual path taken will vary above or below the forecast. These possibilities will be dealt with in **Section VI** on risk analysis. More technical information on methodology, key assumptions, and data sources are found in **Appendix A**.

Population

The financial model included in its analysis all individuals enrolled in MaineCare, including those participating in the Medicaid Savings Plan.[84]

The AG Financial Model utilizes standard actuarial analysis (See **Figure 28)** to predict potential growth in the Baseline scenarios. An important factor used in the analysis is the poverty rate. Because Maine has had a significant increase in its poverty rate, it impacts the forecast on the number of individuals who will become eligible for MaineCare.

Annual Average Projected Growth Factors Based on Actuarial Analysis		
Age Group	**General Population Growth**	**Final Growth Factor When Adjusted for Poverty Growth**
Under 18	-0.0131	0.0308
18-64	0.0046	0.0248
65 and Over	0.0156	0.0361
Total	0.0024	0.0278

Figure 28: Actuarial Projected Growth Rates

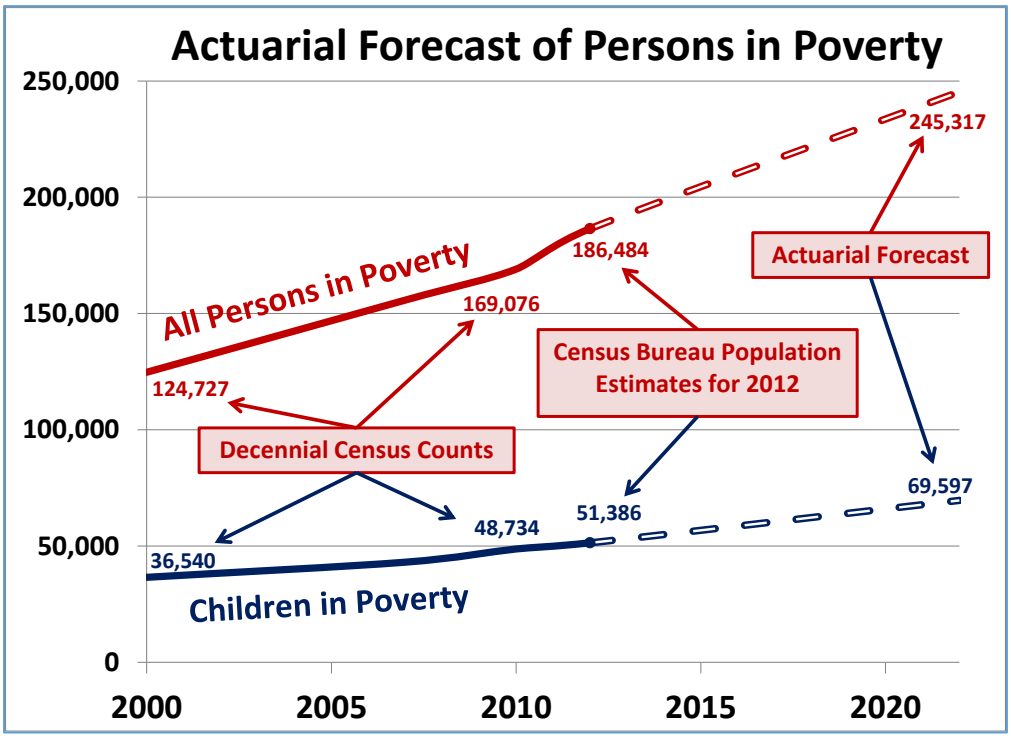

Figure 29: Maine Actuarial Forecast of Persons in Poverty

The graph in **Figure 29** shows the estimated growth in poverty based on historical trends and actuarial assumptions. The actuarial assumptions used for these scenarios are middle values, that is, the actual growth could be somewhat higher or lower than projected. The risks of higher or lower growth are discussed in **Section VI** of this report. Importantly, the growth in poverty will impact both the Baseline as well as the Expansion Scenario.

[84] Medicare buy-in groups with income between 100% of FPL and 175% of FPL who meet the criteria for participation in Drugs for Elderly (DEL) program and/ or Maine Rx were included in the forecast.

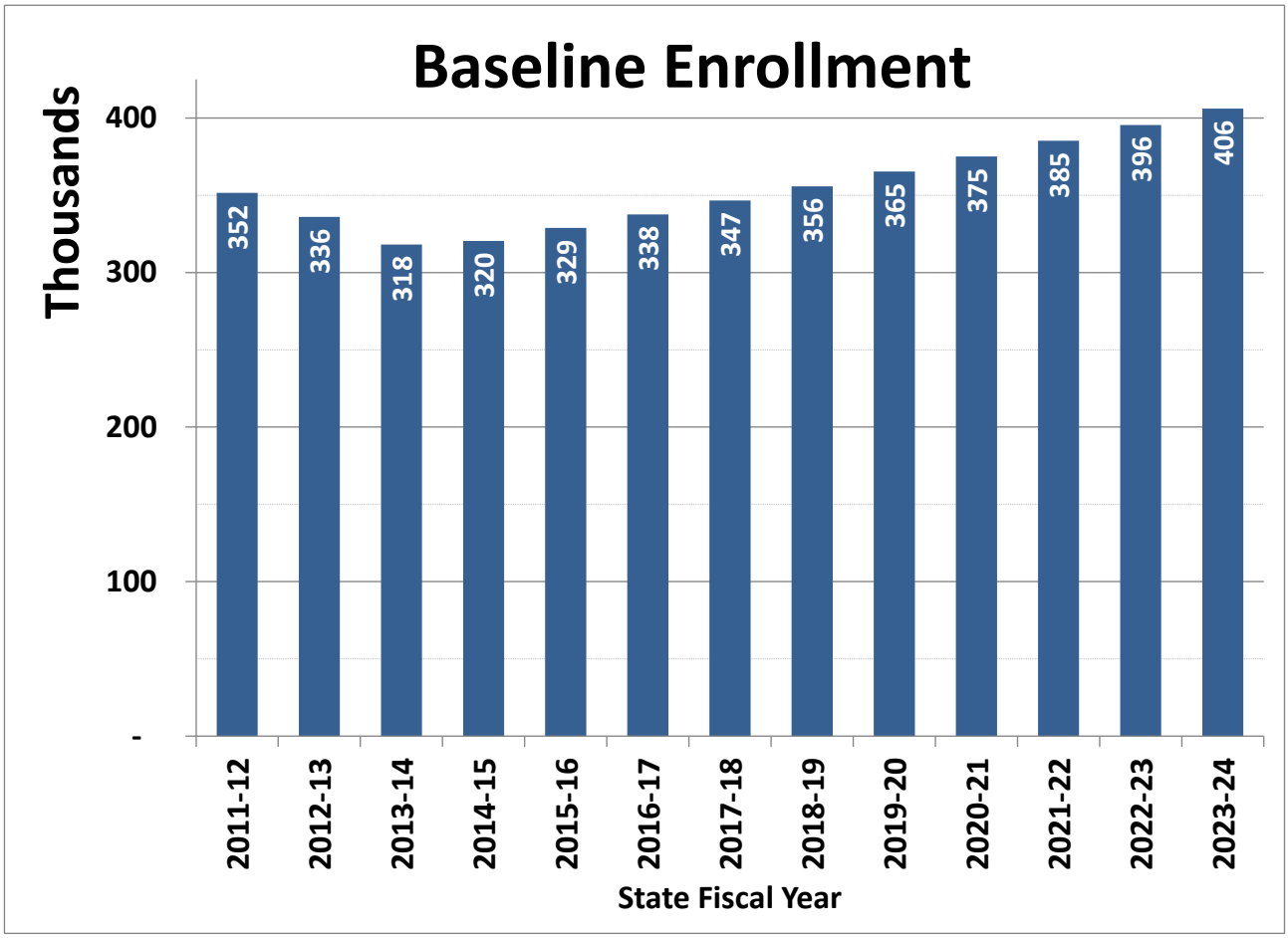

Figure 30: Baseline Enrollment Forecasts

Because of the high poverty growth, the financial model predicts a significant growth in the Baseline scenario, which can be seen in **Figure 30**. Thus, even without expanding eligibility, MaineCare enrollment is projected to grow by an annual average of 2.7% for the Baseline. This may not seem to be tremendous growth, and it is not over one or two years. However, growth rates when sustained compound and grow exponentially. Therefore, a 2.7% annual growth rate over nine years is a total increase of nearly 27%, which would add 85,700 persons to the enrollment, bringing the SFY 2023-24 Baseline enrollment to 406,100.

Under the Expansion Scenario, the population will grow more dramatically. The average annual growth becomes 5.2% over ten years, which would be a total increase of 66.7%. For enrollment excluding those participating in the Medicaid Savings Plan, the growth is even greater: 5.7% over ten years with a total increase of 74.7%.

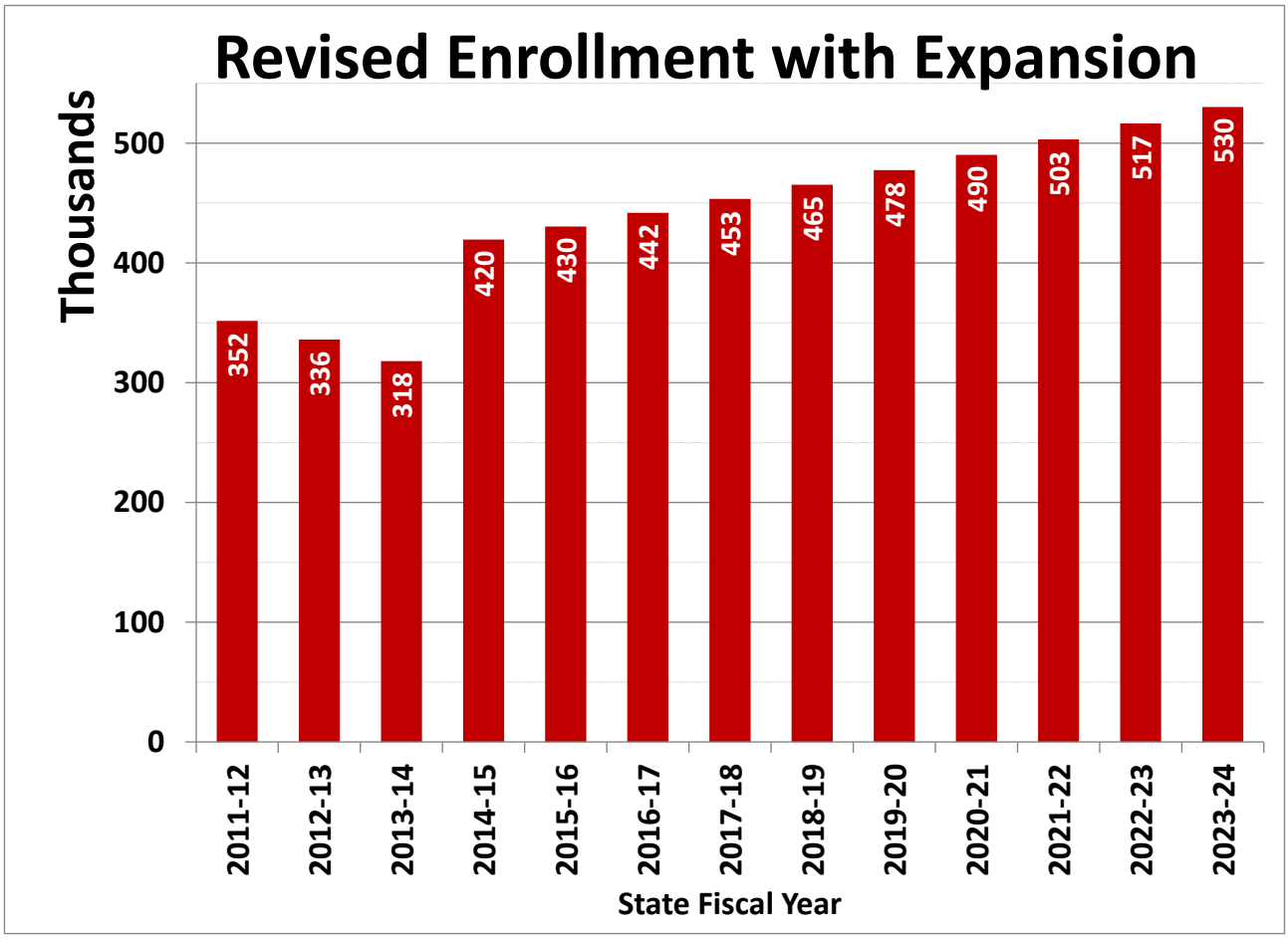

Figure 31: MaineCare Enrollment with Expansion

Enrollment under the Expansion Scenario in SFY 2023-24 would have an additional 212,100 persons than in SFY 2013-14, which includes the anticipated enrollment growth for the Baseline. However, the average annual growth rate can be misleading because there will initially be a large increase in SFY 2014-15.[85] After SFY 2014-15, the average annual growth rate is projected to be 2.6%. (See **Figure 31**.)

For this analysis, the following population groups were assumed to be added to MaineCare:

- Childless adults up through 138% of FPL;
- Parents between 101% and 138% of FPL;
- Persons at 138% of FPL or below currently enrolled in private insurance who would voluntarily drop or lose their coverage;
- Parents at 100% or below FPL currently eligible for MaineCare but who will enroll because of the so-called "woodwork effect"; and

[85] It may take some time before the initial increase in enrollment will be accomplished, which may carry over into the succeeding fiscal year. To keep the model from becoming too complicated, it was assumed all of the initial increase would incur in the first year.

- Children at 200% of FPL or below who will enroll because of the "woodwork effect."

Figure 32 gives the estimated number of new persons from those categories who will likely enroll in MaineCare. The total initial enrollment is estimated to be 99,100 within the first program year, assuming full implementation.[86]

Expansion Enrollment Forecast	SFY 2014-15 Estimate
Childless Adults up to 138% FPL	47,500
Parents between 101% -138% FPL	15,200
Persons 138% FPL and below who would lose private insurance	32,700
Parents 100% FPL and Below ("woodwork")	1,600
Children ("woodwork")	2,100
Total Forecast	**99,100**

Figure 32: Expansion Enrollment for SFY 2014-15

The category of persons losing or voluntarily dropping private coverage requires some explanation. There are two subgroups within this category. First, there are individuals with non-group coverage. The ACA has made many of these more affordable health care plans illegal, and many insurers have recently sent cancellation notices to holders of these policies. Because of federal requirements that plans must include all federally-defined essential health benefits and other regulations, replacement policies are significantly more expensive. That will likely make the costs of the new policies unaffordable for these individuals. If eligibility for Medicaid were expanded, a significant number of these individuals would qualify and likely come onto the MaineCare rolls. The second subgroup is comprised of those individuals with employer-provided coverage. There is evidence through scientific surveys, correlations from historic census data when Maine expanded MaineCare in prior years, and anecdotal evidence that some employers will drop coverage,[87] and those employers that decide against dropping coverage can effectively maneuver to do the same for their low-income employees. Those employers with less than fifty employers are not subject to any federal penalties if they do not offer insurance. From a small business firm's point of view, it makes financial sense to allow the government to pay for employee health coverage than for the firm to incur that cost. Some of these smaller employers, therefore, will likely drop coverage. For larger employers, there are penalties in the law if they do not provide health insurance to their employees, but it may not be necessary for them to drop coverage and sustain the penalties in order for them to encourage their low-income employees to enroll in Medicaid. These employers can simply choose plans with premium cost sharing at high enough levels that make it financially conducive for their low-income employees to enroll in Medicaid. This tactic also could be used by smaller employers as well.

Census data provide estimates on the number of persons without health insurance who are currently eligible for MaineCare as well as parents, children, and childless adults with private insurance coverage with incomes at 138% of FPL or below. According to these data, there are 88,000 persons in Maine who have private insurance with incomes below that threshold. **Appendix A**

[86] Idem.

[87] Shubham Singhai, Jeris Stueland, and Drew Ungerman, "How US health care reform will affect employee benefits," *McKinsey Quarterly,* June 2012, accessed at: http://www.mckinsey.com/insights/health_systems_and_services/how_us_health_care_reform_will_affect_employee_benefits

explains the methodology for estimating the percentage of those persons who would voluntarily drop or lose coverage and subsequently enroll in MaineCare under the Expansion Scenario. In addition, recent Census data in 2012 and 2011 estimate Maine has between 41,200 and 45,600 uninsured persons under 138% of FPL. The methodology for the estimating the take-up rate is discussed in **Appendix A**.

Experience has shown that whenever Medicaid enrollment is expanded, people who are already eligible also enroll. This is called the "woodwork effect."

The last two categories of the expansion population in **Figure 32** deserve further explanation. Experience has shown that whenever Medicaid enrollment is expanded, people who are already eligible also enroll. So, in addition to new categories that expand the enrolled population, there is also an increase in established programs. This phenomenon has been crudely called the "woodwork effect." It comes from the expression that "they come out of the woodwork," because Medicaid administrators had not counted on the increased enrollment. This phenomenon is thought possible because not everyone who qualifies for Medicaid signs up, for whatever reason he or she might have for not doing so. Some have suggested that the term "woodwork effect" has a negative connotation and have offered the term "welcome mat effect" as its replacement.

Figure 33 provides an illustration comparing enrollment under the Baseline with the Expansion Scenario. The difference in the lines gives the growth in enrollment due to the expansion.

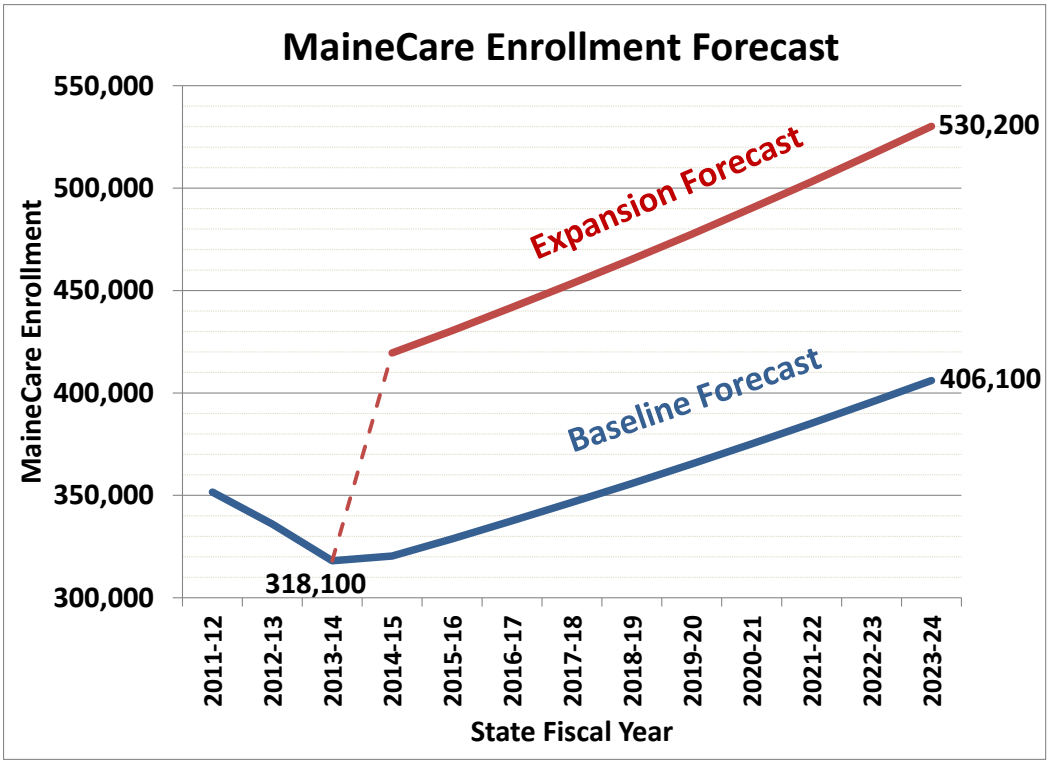

Figure 33: MaineCare Enrollment Forecasts Comparison

Fiscal Cost

The AG Financial Model shows that in these scenarios the total cost for the Baseline and Expansion Scenario will be significant. For the Baseline, total costs will increase on average of 5.5% per year, which increases the total cost by 70.5% over a ten-year period. Under the Baseline, the total cost for MaineCare increases by $1.9 billion, from $2.7 billion in SFY 2013-14 to $4.6 billion in SFY 2023-24. For the Expansion Scenario, the total cost of MaineCare more than doubles to $5.5 billion in SFY 2023-24, an increase of 105%. The average annual increase over those ten years is projected to be 7.4%, although in the latter years it would fall closer to 5.7%.

The results of these scenarios generated by the AG Financial Model estimate growth comparable to the national average as estimated by the USDHHS Office of the Actuary, discussed earlier in this report. Although Maine lacks the population growth of other states, its high poverty growth rate makes up for the difference.

The federal government will be absorbing the lion's share of the expansion cost in the early years. However, it would be incorrect to assume that Maine would not have any costs. Quite to the contrary, the costs will still be significant. The ACA provides 100% reimbursement for expenditures in calendar years (CY) 2014 through 2016 only for new eligibility groups. Because MaineCare has allowed more groups to become eligible prior to the enactment of the ACA, including parents above 100% of FPL, Maine would clearly receive 100% reimbursement for those years for only the childless-adult population with one possible exception. At the time that the ACA became effective, Maine had 10,500 childless adults enrolled in its Childless Adult Waiver program. These adults would likely receive an enhanced FMAP but still lower than the FMAP for the newly eligible groups. However, MDHHS is currently negotiating with CMS in order to receive the higher FMAP in the event the state decides to expand.

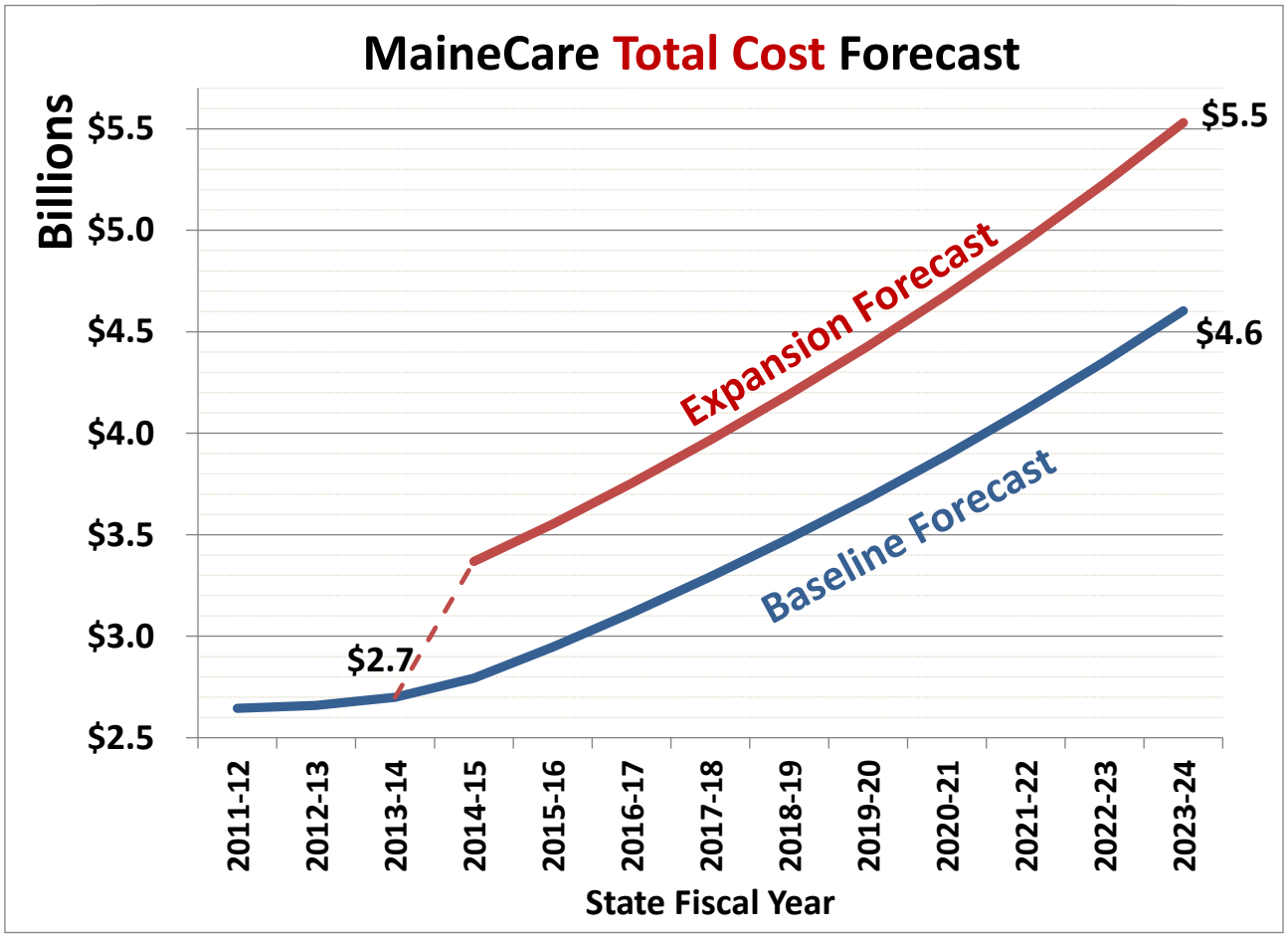

Figure 34: MaineCare Total Cost Forecast

Figure 34 illustrates the difference in the total MaineCare costs between the Baseline and Expansion Scenario. Even for those categories that receive 100% reimbursement, the Federal commitment would decrease beginning in CY 2017, until it becomes 90% in CY 2020. The Expansion Scenario assumes the Federal government will continue to provide 90% after 2020, but this assumption is not assured considering the fiscal situation of the federal government.

The expansion scenario assumes the Federal government will continue to provide 90% funding after 2020, but this assumption is not assured considering the fiscal situation of the federal government.

Given these assumptions, the AG Financial Model predicts state costs of $33.5 million in SFY 2014–15, or $45.3 million if the higher FMAP is denied for the childless adult waiver population when compared to the Baseline. (See **Figure 35**.) The state costs are projected to grow to $125.0 million in SFY 2023–24, for a ten-year total of $807 million, or $840 million if the higher FMAP is denied.

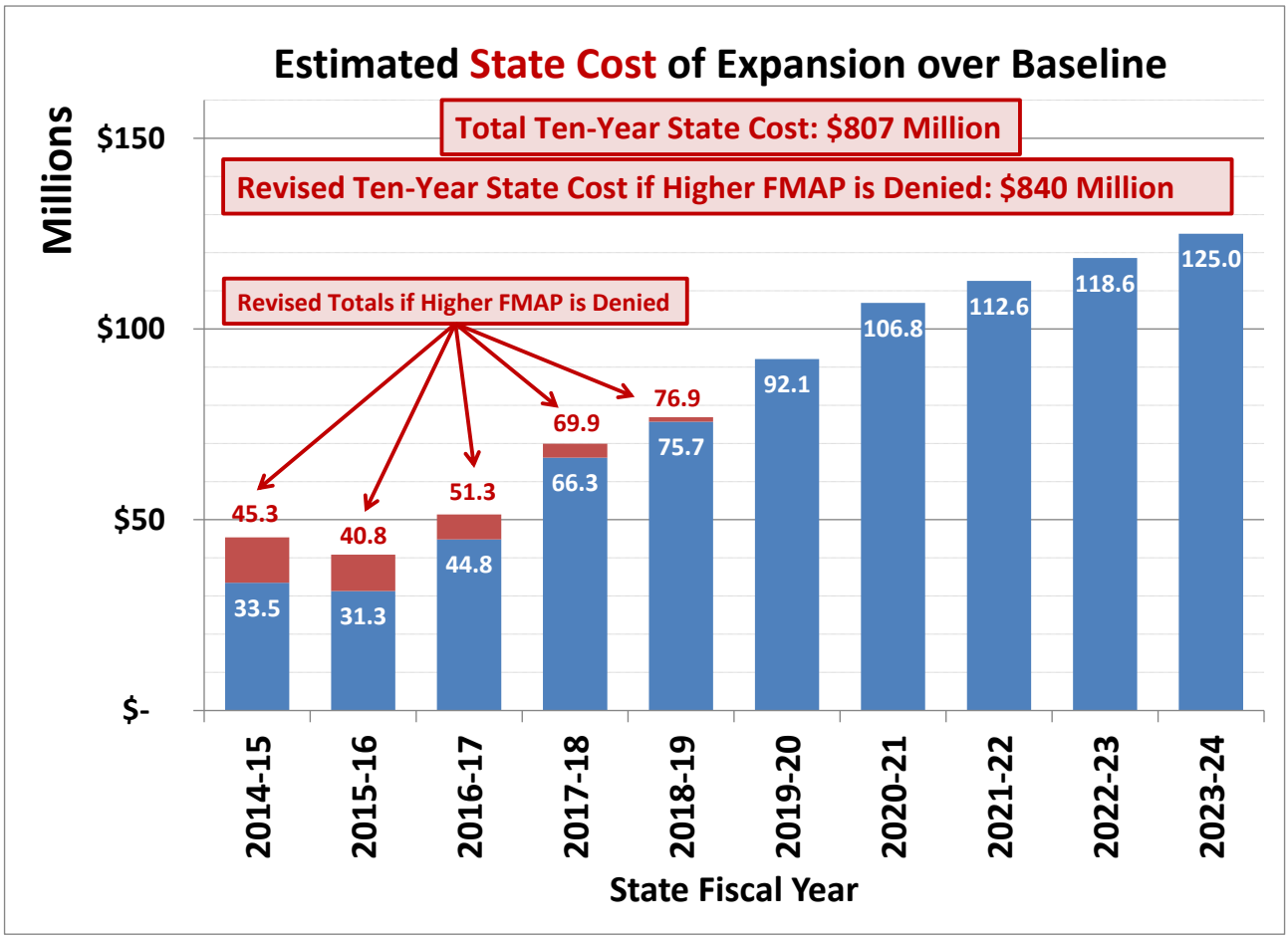

Figure 35: Estimated State Cost of Expansion over Baseline

Figure 36 provides a more detailed summary of the scenario results of the AG Financial Model, which includes the Baseline, the Expansion Scenario, and the impact. It gives the projected populations, total costs, federal costs, and state costs.

The Alexander Group Financial Model Results for Medicaid Expansion in Maine: Dollars in Millions														
	SFY:	2012-13 Actual	2013-14 Estimate	2014-15 Forecast	2015-16 Forecast	2016-17 Forecast	2017-18 Forecast	2018-19 Forecast	2019-20 Forecast	2020-21 Forecast	2021-22 Forecast	2022-23 Forecast	2023-24 Forecast	Ten Year Total
Baseline Projections	Enrollees	336,000	318,100	320,400	328,800	337,600	346,600	355,800	365,300	375,100	385,200	395,500	406,100	
	Total Cost	$ 2,659	$ 2,700	$ 2,794	$ 2,946	$ 3,114	$ 3,292	$ 3,481	$ 3,681	$ 3,892	$ 4,116	$ 4,353	$ 4,604	$ 36,274
	Fed Cost	$ 1,612	$ 1,622	$ 1,664	$ 1,768	$ 1,872	$ 1,978	$ 2,090	$ 2,209	$ 2,335	$ 2,468	$ 2,609	$ 2,758	$ 21,752
	State Cost	$ 1,047	$ 1,077	$ 1,130	$ 1,178	$ 1,242	$ 1,314	$ 1,391	$ 1,472	$ 1,557	$ 1,648	$ 1,744	$ 1,846	$ 14,522
Expansion Scenario	Enrollees			419,500	430,400	441,800	453,400	465,300	477,500	490,200	503,200	516,500	530,200	
	Total Cost			$ 3,369	$ 3,552	$ 3,753	$ 3,966	$ 4,191	$ 4,430	$ 4,682	$ 4,949	$ 5,231	$ 5,530	$ 43,653
	Fed Cost			$ 2,205	$ 2,343	$ 2,466	$ 2,586	$ 2,725	$ 2,866	$ 3,018	$ 3,188	$ 3,368	$ 3,559	$ 28,324
	State Cost			$ 1,164	$ 1,209	$ 1,287	$ 1,381	$ 1,466	$ 1,564	$ 1,664	$ 1,761	$ 1,863	$ 1,971	$ 15,329
Expansion Impact	Enrollees			99,100	101,600	104,200	106,800	109,500	112,200	115,100	118,000	121,000	124,100	
	Total Cost			$ 575	$ 606	$ 639	$ 674	$ 710	$ 749	$ 790	$ 833	$ 878	$ 926	$ 7,379
	Fed Cost			$ 541	$ 575	$ 594	$ 607	$ 635	$ 657	$ 683	$ 720	$ 759	$ 801	$ 6,573
	State Cost			$ 33	$ 31	$ 45	$ 66	$ 76	$ 92	$ 107	$ 113	$ 119	$ 125	$ 807

Figure 36: The Alexander Group Financial Model Results

Fiscal Impact

With Medicaid expansion, 37.9% of Maine's population will be enrolled in Medicaid by SFY 2023-24.

Maine already has a relatively high percentage of its overall state population enrolled in MaineCare, which was 24.7% in SFY 2012-13. (See **Figure 37**.) Based on the actuarial assumptions used in this financial model, 29.0% of the overall state population will be enrolled in Medicaid by SFY 2023-24 under the Baseline. Under the Expansion Scenario, however, 37.9% of the overall state population will be enrolled in Medicaid. Carrying the health-care needs of more

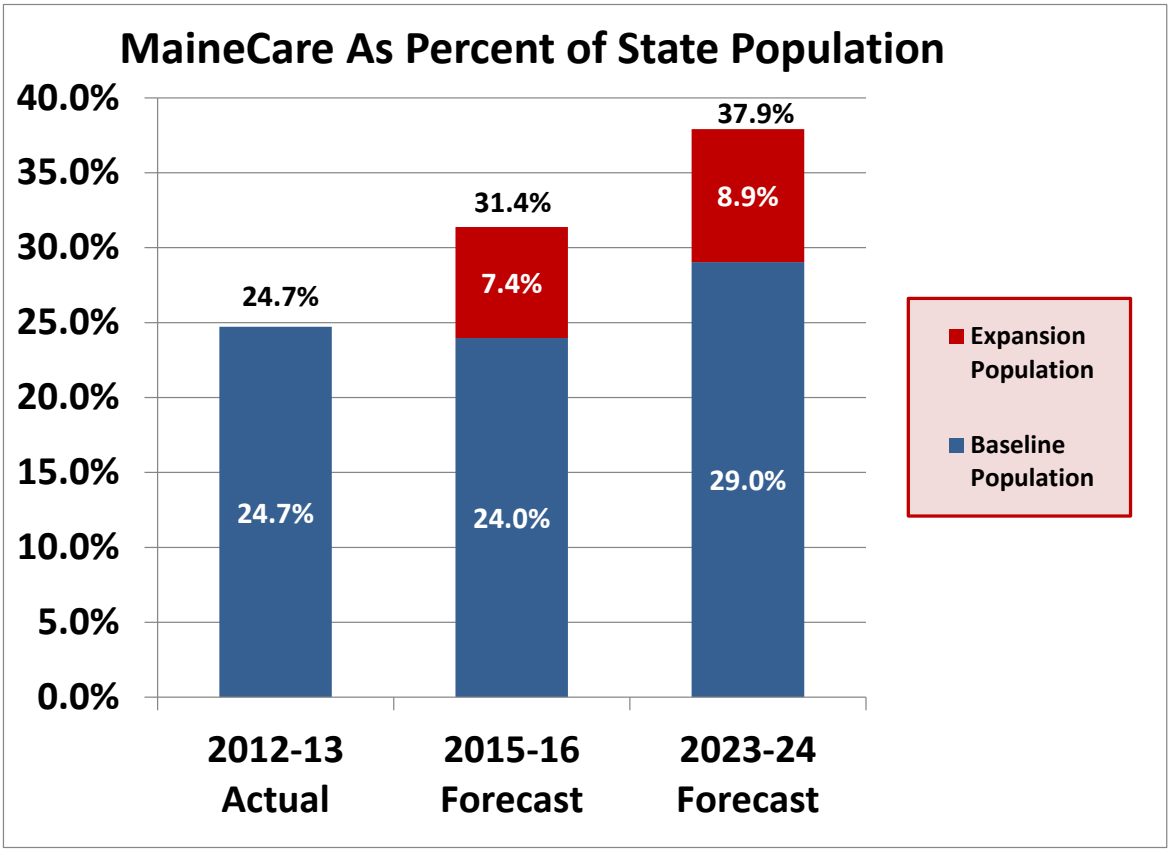

Figure 37: MaineCare as a Percent of State Population

than one third of the population will be challenging under any circumstance. Average costs to fund healthcare for members enrolled in MaineCare vary greatly among population groups, from as little as $3,848 annually in SFY 2012–13 for children under 100% of FPL to $18,641 for individuals with disabilities.

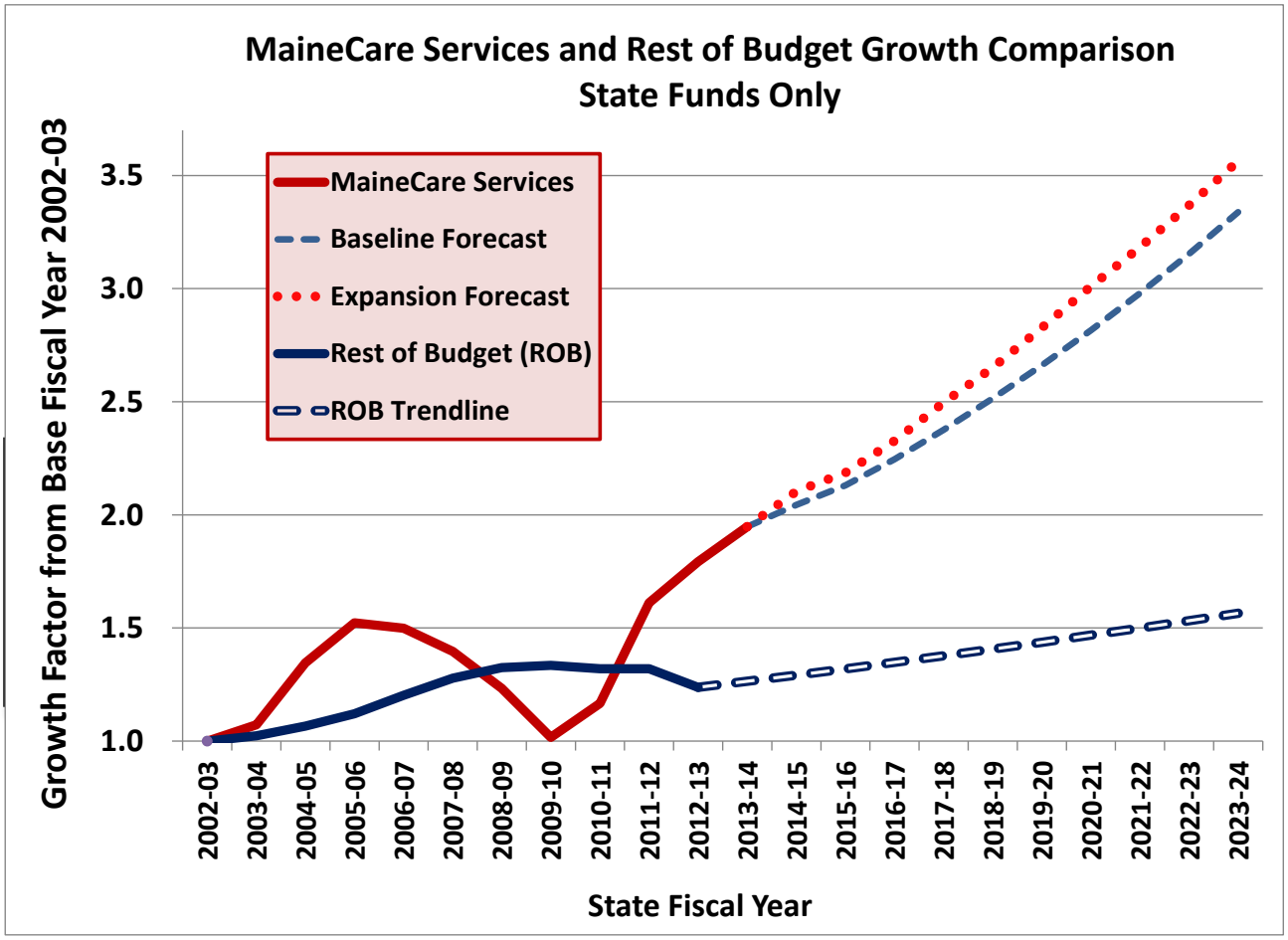

Figure 38: MaineCare Services and Budget Growth Comparison

In terms of state funds, the budget for MaineCare services has been growing faster than the rest of the state budget, almost three times as fast over the past ten years (6.0% average annual growth versus 2.2%). The AG Financial Model forecasts that the Baseline average annual growth rate will be 5.5%. However, if Maine elects to expand the MaineCare eligibility, the forecasted growth rate becomes 6.2%. **Figure 38** illustrates the differences in the growth rates, which are the financial obligations that must be paid for using state funds. The large dip in the state obligation for MaineCare services seen on the chart occurred because the federal government, through the American Recovery and Reinvestment Act of 2009, provided states with one-time grants to help pay for Medicaid and balance their budgets during the last recession. Importantly, these differences in the growth rates raise an obvious fiscal concern: the state will continually have to generate additional revenue to support the program, even without the expansion.

The varying growth rates will cause MaineCare services, i.e., excluding administrative costs, to continually encompass a larger share of the state budget in regards to both state funds and federal funds. **Figure39** shows the results of estimating the budget impact. Historic growth rates were used to estimate the size of the rest of the budget along with the results of the AG Financial Model for estimating the costs of MaineCare services. Examining just the General Fund, the percentage of the General Fund budget dedicated to MaineCare services was 20.3% in SFY 2002–03. This percentage grew to 24.2% in SFY 2012–13, and the AG Financial Model forecasts that it will become 36.2% in SFY 2023–24 under the Baseline. It might be noted that the percentage for SFY 2012-13 would be even higher if MaineCare were not supplemented with $255 million from other special revenue accounts. Under the Expansion Scenario, however, MaineCare will require 38.7% of the General Fund budget. For the overall budget, including federal funds, MaineCare will require 45.3% of the total budget under the Expansion Scenario in SFY 2023-24 as opposed to 40.2% under the Baseline.

Percent MaineCare Services to Total Maine State Budget by Fund								
SFY	Baseline				Expansion			
	General Fund	All State Funds	Federal	Total	General Fund	All State Funds	Federal	Total
2002-03 (Actual)	20.3%	13.9%	59.0%	29.0%	N/A	N/A	N/A	N/A
2012-13 (Actual)	24.2%	19.0%	59.2%	32.2%	N/A	N/A	N/A	N/A
2023-24 (Forecast)	36.2%	25.7%	65.8%	40.2%	38.7%	27.4%	71.4%	45.3%

Figure 39: MaineCare Services as Percent of Maine State Budget by Fund

Although an economic impact statement is beyond the scope of this study, an observation is offered. First, however, a word needs to be said about a number of recent economic studies that have been produced predicting economic benefits for states that expand. These studies appear to use theoretical assumptions from the Neo-Keynesian school of economic thought. They generally use models that apply a multiplier to new spending to demonstrate increased economic activity. These models are seriously deficient, however, because they do not adequately account for all economic losses from the revenue side of the equation. A more viable model would also estimate the opportunity costs due to the increased taxation, government borrowing, and other impacts. It is the net of the benefits and losses that defines the economic impact.

The enrollment to employment ratio changes under expansion. In SFY 2012–13, the ratio was 1 to 1.8, meaning that each person on MaineCare was supported by 1.8 employed persons. The forecasts show that that ratio will drop to 1 to 1.3 in 2020 under the expansion scenario.

One quick way to evaluate the economic impact is to compare MaineCare enrollment to employment. This gives an indication of the burden placed on the employed who support the system. This is not an exact indicator by any means, but it nevertheless provides a rough indication. It is, after all, those who are employed who pay the bulk of taxes to support not only state

government but the federal government as well. Using data from these sources—the U.S. Bureau of Labor Statistics, the Center for Workforce Research and Information of the Maine Department of Labor, and the Maine Department of Health and Human Services—and forecasts from the AG Financial Model, the enrollment to employment ratio changes under the Expansion Scenario. In SFY 2012–13, the ratio was 1 to 1.8, meaning that each person on MaineCare was supported by 1.8 employed persons. The forecasts show that that ratio will drop to 1 to 1.3 in 2020 under the Expansion Scenario. (See **Figures 40 and 41.)**

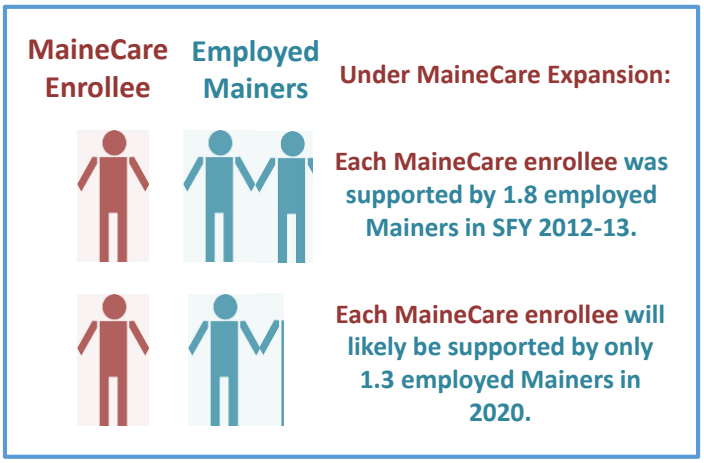

Figure 40: MaineCare Enrollees to Employed Mainers Ratio

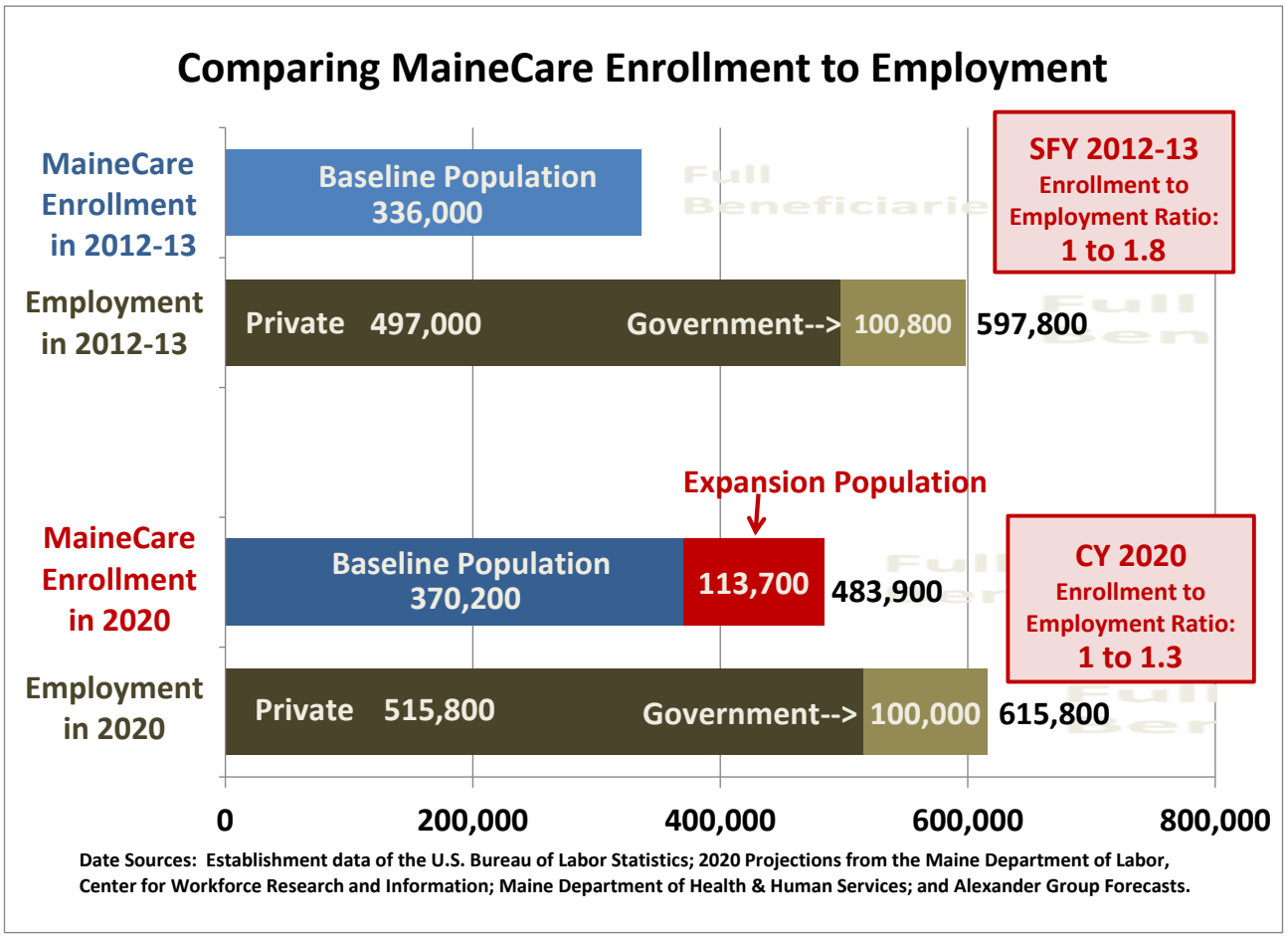

Figure 41: Comparing MaineCare Enrollment to Employment

Conclusion on Results of Financial Model

> The results of the baseline and expansion scenarios will challenge Maine to generate additional revenue in state funds to keep up with the growing demand for MaineCare.

From a financial standpoint, the results from the Baseline and Expansion Scenarios are troublesome. Critical factors, such as poverty growth, are causing MaineCare to continue to have high-cost growth far in excess of other budgetary growth. In other words, the State of Maine will be challenged to generate additional revenue in state funds to keep up with the growing demand for MaineCare under the Baseline, which is projected to require 36.2% of the General Fund budget in SFY 2023-24 when it now requires 24.2% of the General Fund budget. For the Expansion Scenario, the state of Maine would be required to generate an additional $807 million to $840 million in state funds over the next ten years in addition to what is required to support MaineCare under the Baseline. The next section examines risks to these forecasts.

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Section VI: Risk Analysis

Overview

The data generated by the financial model to forecast enrollment and costs for the Baseline and Expansion Scenario are based on a number of key assumptions on values of factors that will determine what trends will prevail in the future. Each value chosen was in the middle of an expected range of possibilities. For example, the PMPM growth factor has an expected value range of 1.9% to 3.9%, and 2.9% was the chosen value for the forecast. There is risk, however, that the actual value that will be realized in the future will fall toward either end of the range as opposed to in the middle. Low-end values are defined as those values that would cause enrollment and costs to be lower than forecasted. High-end values are those values that would cause enrollment and cost to be more than forecasted. This section of the report provides analysis on the four most likely risk factors.

The Risk Factors Considered

The four risk factors chosen to be analyzed are the poverty growth rates, PMPM cost growth rates, individuals with private insurance losing coverage (private drop), and FMAP rate changes. (See **Figure 42**.)

Risk Factors Examined		
Risk Factor	**Explanation**	**Impact**
Poverty Growth	Small changes in poverty growth influences welfare rolls.	Impacts size of population eligible for MaineCare and overall state budget.
PMPM	Health care costs have been increasing, and Maine's fee reimbursement rate relative to private insurers is one of the lowest in the country.	Rising costs impact total program costs and the state budget.
Private Drop	Persons losing coverage within defined income ranges can become eligible for MaineCare.	Impacts size of population eligible for MaineCare and overall state budget.
FMAP	FMAP rates determine cost sharing between the federal government and state governments.	Changes in FMAP rates have significant impact on state budgets.

Figure 42: Risk Factors Examined

Each of the succeeding pages presents three possibilities for each risk factor:

- "Low end" values are those values that result in the overall decrease in costs, which may include reductions in enrollment, relative to what is expected.
- "High-end" values are those values that result in the overall increase in costs, which may include increases in enrollment, relative to what is expected.

- 'Middle" values are values between the low-end and high-end and are subsequently considered to be more likely or "what is expected." These middle values are also the assumptions that were chosen in the scenarios presented in **Section V**.

The above values impact both the Baseline and Expansion Scenarios.

The next four subsections provide analyses on the potential low-end and high-end values for the four risk factors listed above. The fifth and sixth subsections below provide analyses on what might be best-case scenarios and worst-case scenarios. The fifth subsection assumes that the three of the four risk factors will have values that fall on the low-end and high-end of their respective ranges. The three factors chosen are those factors most likely to vary from the middle. The sixth subsection assumes all risk factors turn out to be either favorable or unfavorable.

At the top of each subsection below are three summary boxes as follows:

- **Summary Box 1** provides the low-end, middle, and high-end values for the risk factor being considered.

- **Summary Box 2** provides a summary of the impact assuming the low-end and high end values on four program metrics as they relate to the Baseline and Expansion Scenarios. The four program metrics are enrollment in SFY 2023-24, percent of the population on MaineCare in SF 2023-24, the ten-year total cost in millions of dollars, and the ten-year state cost in millions of dollars. This box shows the impact of those values on those metrics by showing how results vary assuming the middle value, the low-end value, and the high-end value. The box further shows the differences and percent changes from the middle value to both the low-end and high-end results.

- **Summary Box 3** shows how the results change by assuming the low-end and high-end values and their impact on the Expansion Scenario relative to the Baseline. For example, the result of a low-end value assumption for Expansion Scenario would be compared to the Baseline assuming the same low-end value. The four metrics considered are the additional enrollment for SFY 2023-24, the additional percentage of the population on MaineCare in SFY 2023-24, the additional ten-year *total* cost in millions of dollars, and the additional ten-year *state* cost in millions of dollars.

Poverty Growth Risk Factor

Actuarial analysis was used to evaluate the poverty growth factor in Maine, which has been very high as explained earlier in the report. If the poverty rate increases more than expected, it will lead to more persons qualifying for MaineCare. Likewise, if it grows less than expected, it can reduce the number. **Figures 43, 44, and 45** summarize potential factors and results.

Summary Box 1			
Population Growth Factors			
Age Category	**Low End**	**Middle**	**High End**
Under 18	2.31%	3.08%	3.85%
18 to 64	1.86%	2.48%	3.10%
65 and over	2.71%	3.61%	4.51%
Total	2.09%	2.78%	3.48%

Figure 43: Poverty Growth Risk Factors

Summary Box 2								
Poverty Growth Risk Factor Changes to Assumed Middle Values								
Scenario and Program Metric		**Middle**	**Low End**			**High End**		
		Result	**Result**	**Difference**	**%**	**Result**	**Difference**	**%**
Baseline	Enrollment in SFY 2023-24	406,100	382,000	-24,100	-5.9%	431,900	25,800	6.4%
	Percent of Population on MaineCare in SFY 2023-24	29.0%	27.3%	-1.7%		30.9%	1.8%	
	10 Year Total Cost (Millions $)	36,274	34,865	(1,409)	-3.9%	37,750	1,476	4.1%
	10 Year State Cost (Millions $)	14,522	13,948	(575)	-4.0%	15,124	602	4.1%
Expansion	Enrollment in SFY 2023-24	530,200	499,100	-31,100	-5.9%	563,200	33,000	6.2%
	Percent of Population on MaineCare in SFY 2023-24	37.9%	35.7%	-2.2%		40.3%	2.4%	
	10 Year Total Cost (Millions $)	43,653	42,020	(1,633)	-3.7%	45,362	1,708	3.9%
	10 Year State Cost (Millions $)	15,329	14,725	(604)	-3.9%	15,962	633	4.1%

Figure 44: Poverty Growth Risk Factor Changes to Assumed Middle Values

Summary Box 3							
Expansion Impact of Poverty Growth Risk Factors							
Scenario and Program Metric		**Low End**		**Middle**		**High End**	
		Increase	**%**	**Increase**	**%**	**Increase**	**%**
Impact to Baseline	Additional Enrollment in SFY 2023-24	117,100	30.7%	124,100	30.6%	131,300	30.4%
	Additional % of Population on MaineCare in SFY 2023-24	8.4%		8.9%		9.4%	
	Additional 10 Year Total Cost (Millions $)	7,155	20.5%	7,379	20.3%	7,611	20.2%
	Additional 10 Year State Cost (Millions $)	777	5.6%	807	5.6%	837	5.5%

Figure 45: Expansion Impact of Poverty Growth Risk Factors

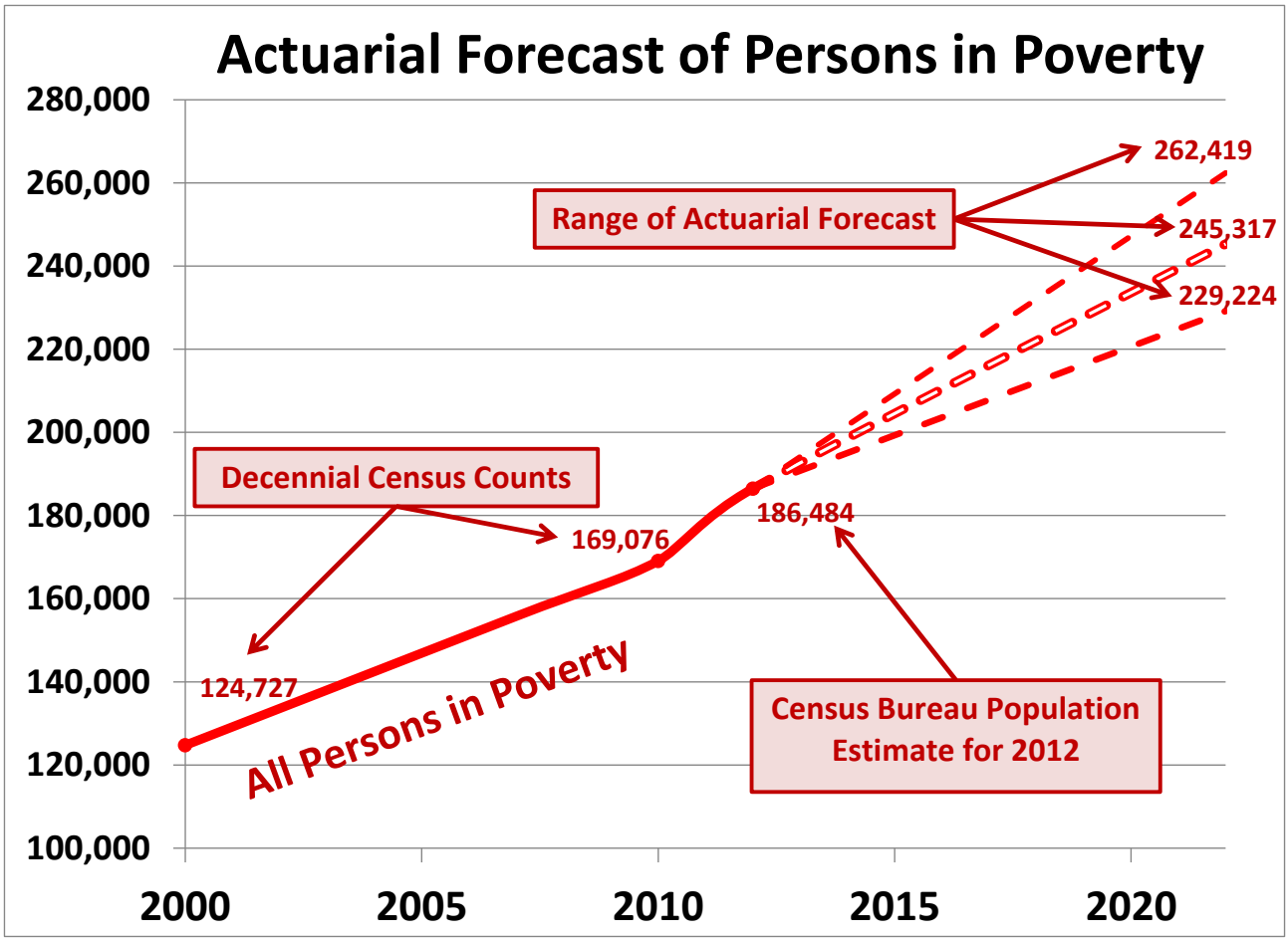

Figure 46: Range of Actuarial Forecast of Persons in Poverty

Poverty Growth Risk Factor Impact on Total Poverty Chart: A change in the growth factor will impact the number of persons in poverty. **Figure 46** summarizes the impact of the various growth factors. The solid line indicates Census Bureau estimates on the number of persons in poverty. The dotted lines are forecasts using actuarial assumptions.

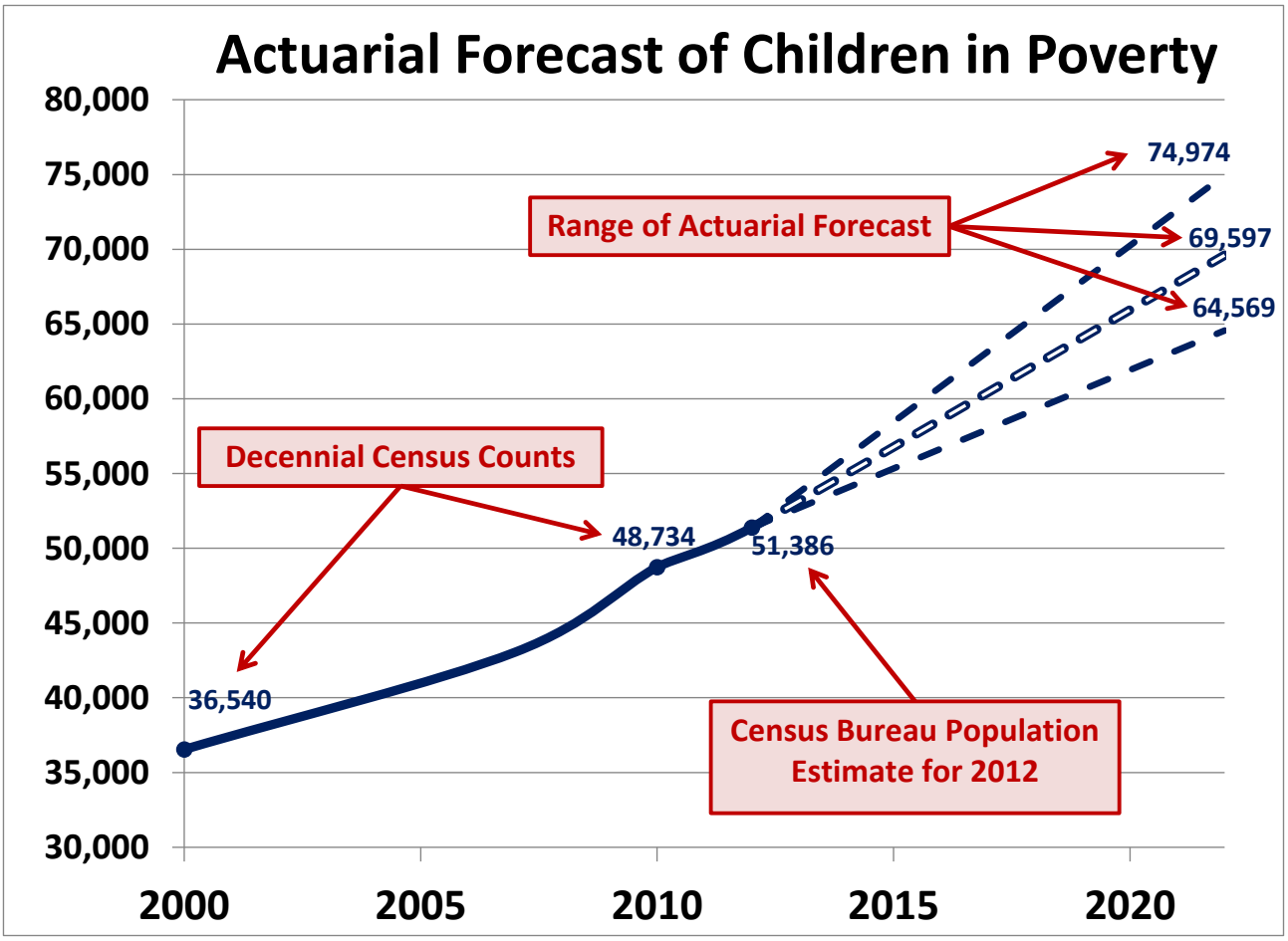

Figure 47: Range of Actuarial Forecast of Children in Poverty

Poverty Growth Risk Factor Impact on Children Chart: Figure 47 shows how the different growth factors would impact the forecast for children living in poverty. The solid line indicates Census Bureau estimates on the number of children in poverty. The dotted lines are forecasts using actuarial assumptions.

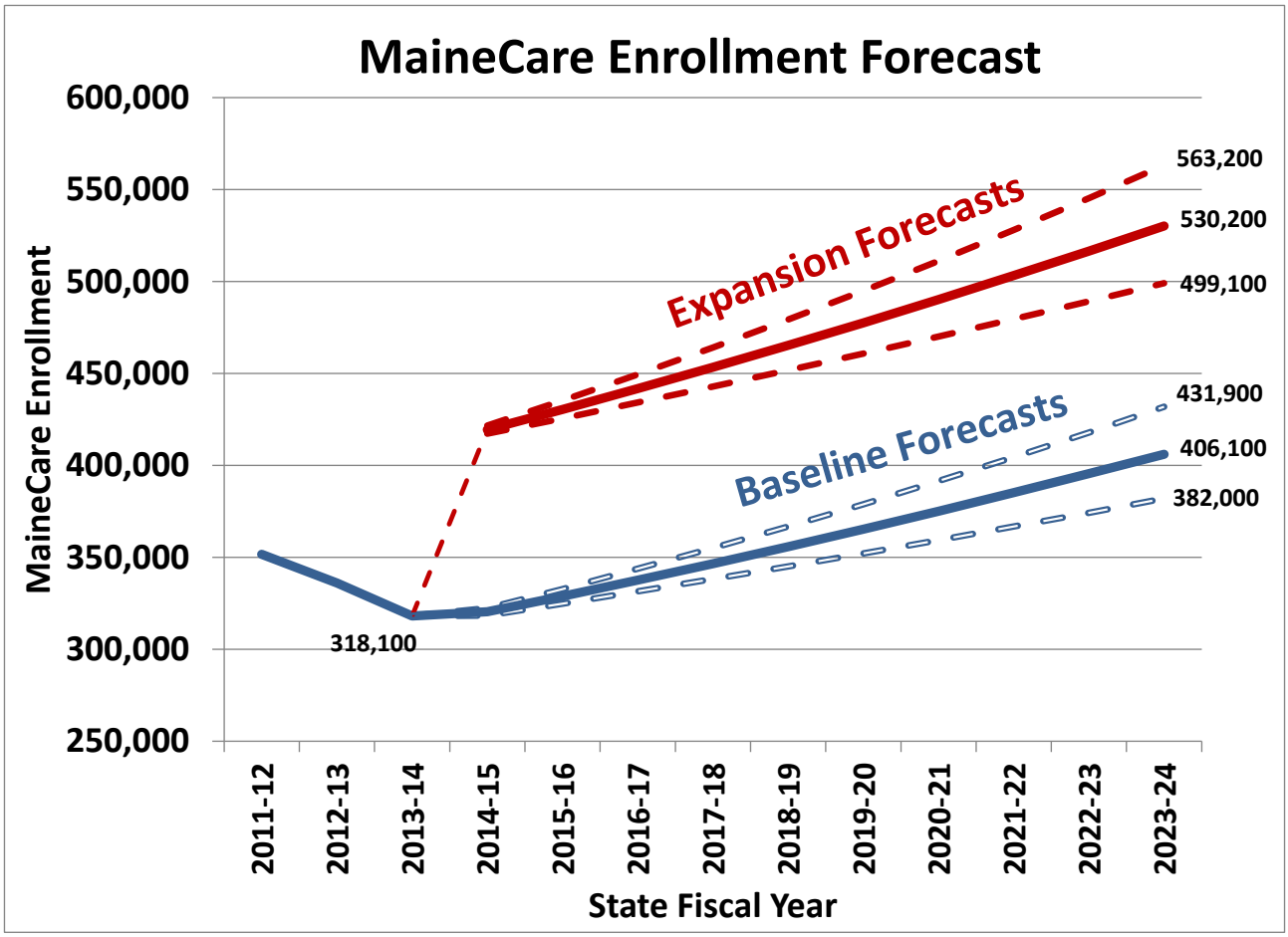

Figure 48: Poverty Risk Factor Impact on MaineCare Enrollment

Poverty Growth Risk Factor Impact on MaineCare Enrollment: Figure 48 displays how different poverty growth factors would impact MaineCare enrollment.

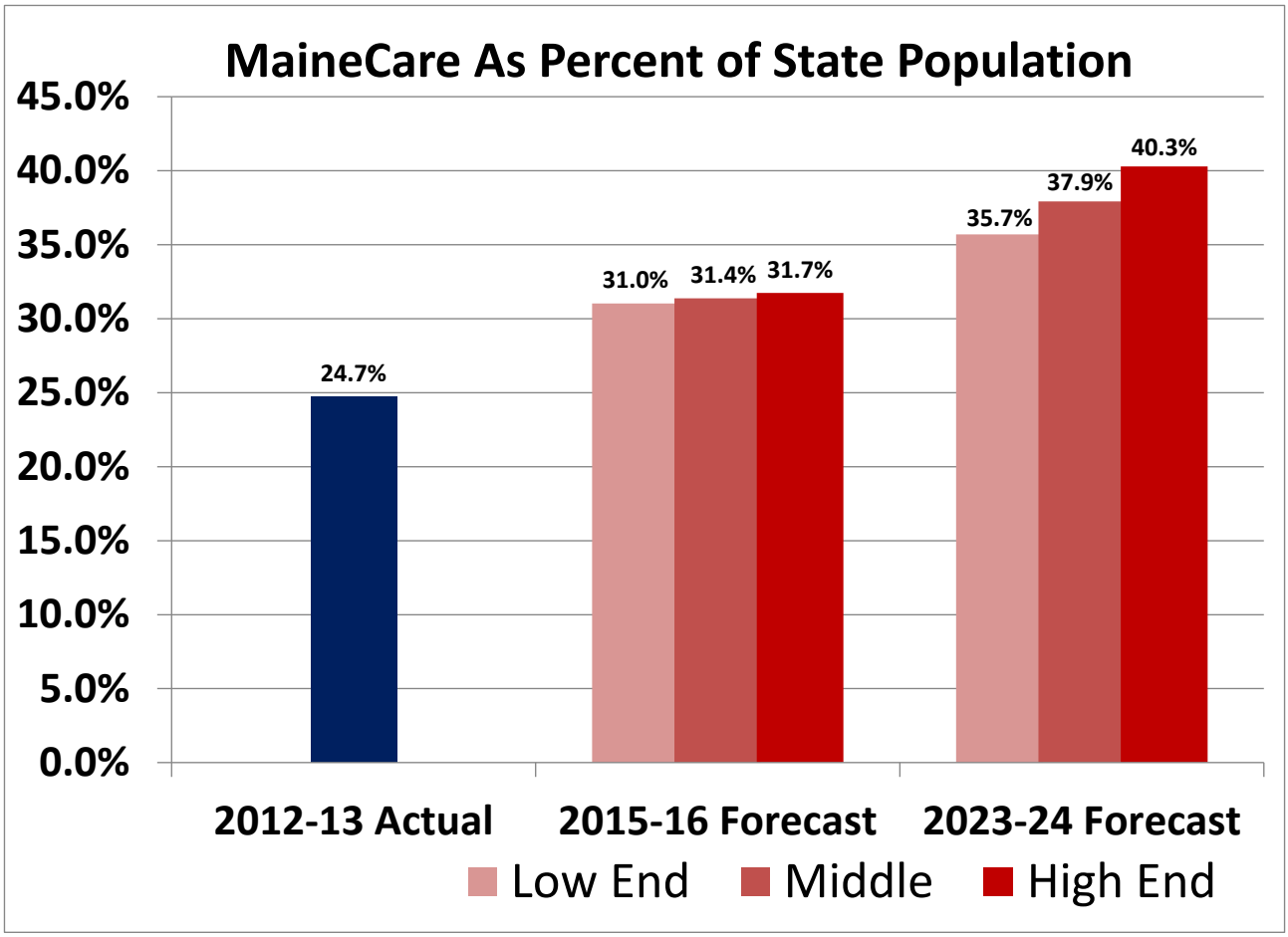

Figure 49: Poverty Risk Factor Impact on MaineCare as Percent of State Population

Poverty Growth Risk Factor Impact on MaineCare as a Percent of State Population: Assuming the low-end factors for poverty growth, it is anticipated that with expansion 35.7% of the Maine population would be serviced by MaineCare by SFY 2023-24. If the poverty rate grows more quickly than anticipated, 40.3% of the population would be serviced by MaineCare. (See **Figure 49**.)

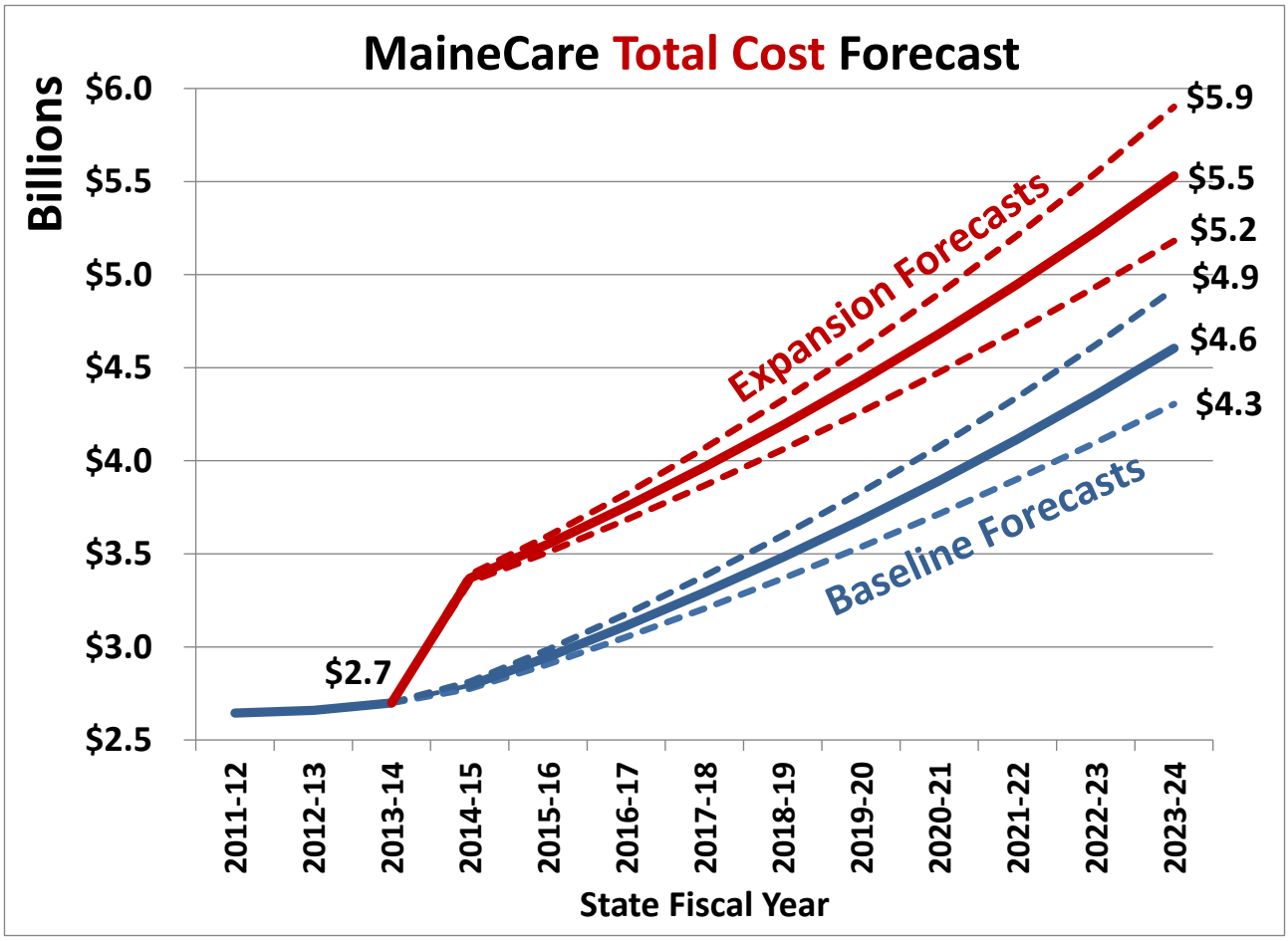

Figure 50: Poverty Risk Factor Impact on Total Cost of MaineCare

Poverty Growth Risk Factor Impact on Total Cost of MaineCare: This chart provides a graphic presentation on how the total costs can vary based on the potential variability in poverty growth rates. (See **Figure 50**.)

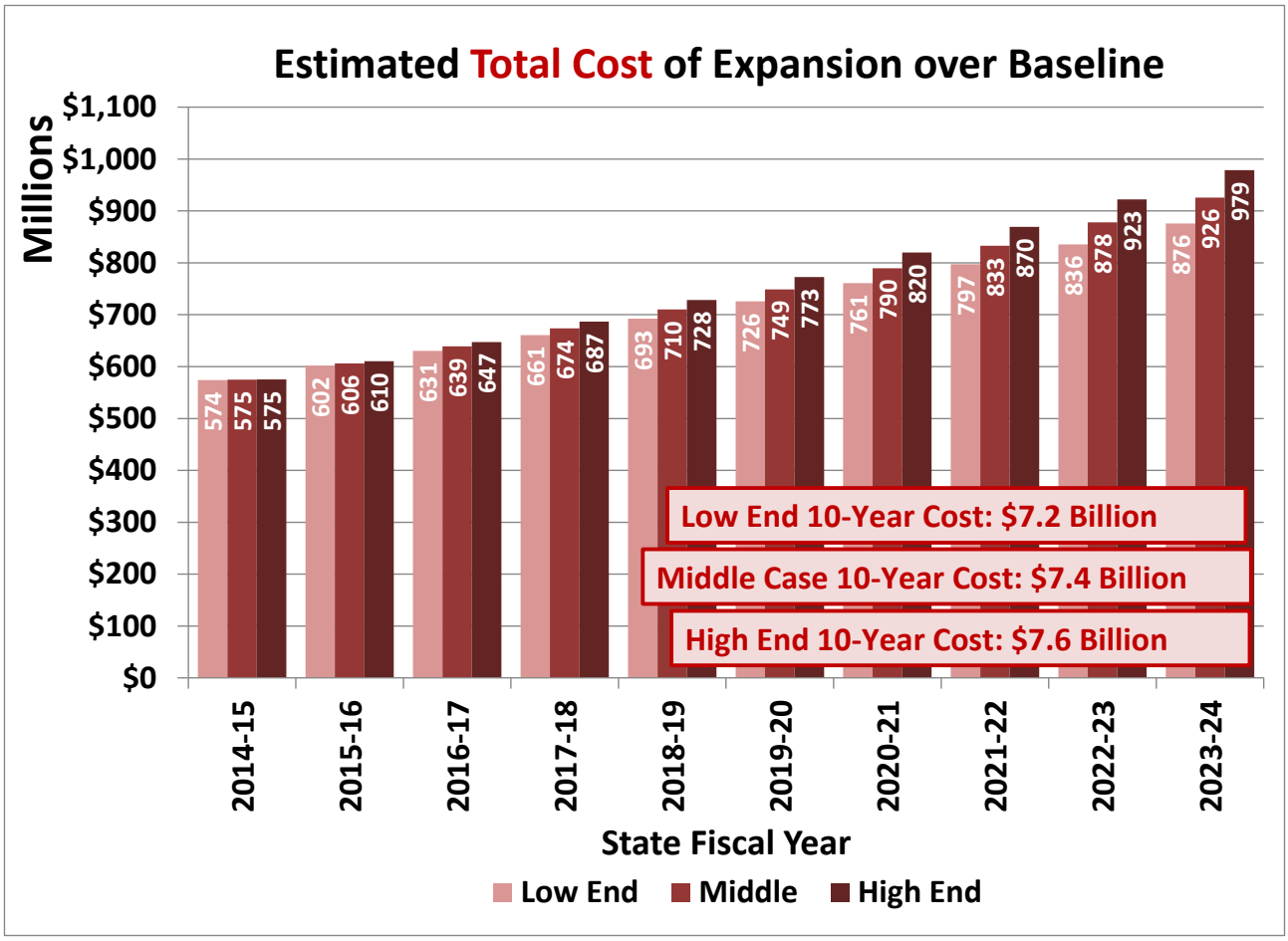

Figure 51: Poverty Risk Factor Impact on Total Cost of Expansion Relative to the Baseline

Poverty Growth Risk Factor Impact on Total Cost of Expansion Relative to the Baseline: This chart provides a graphic presentation on how the total costs of the Expansion Scenario relative to the Baseline can vary based on the potential variability in poverty growth rates. (See **Figure 51**.)

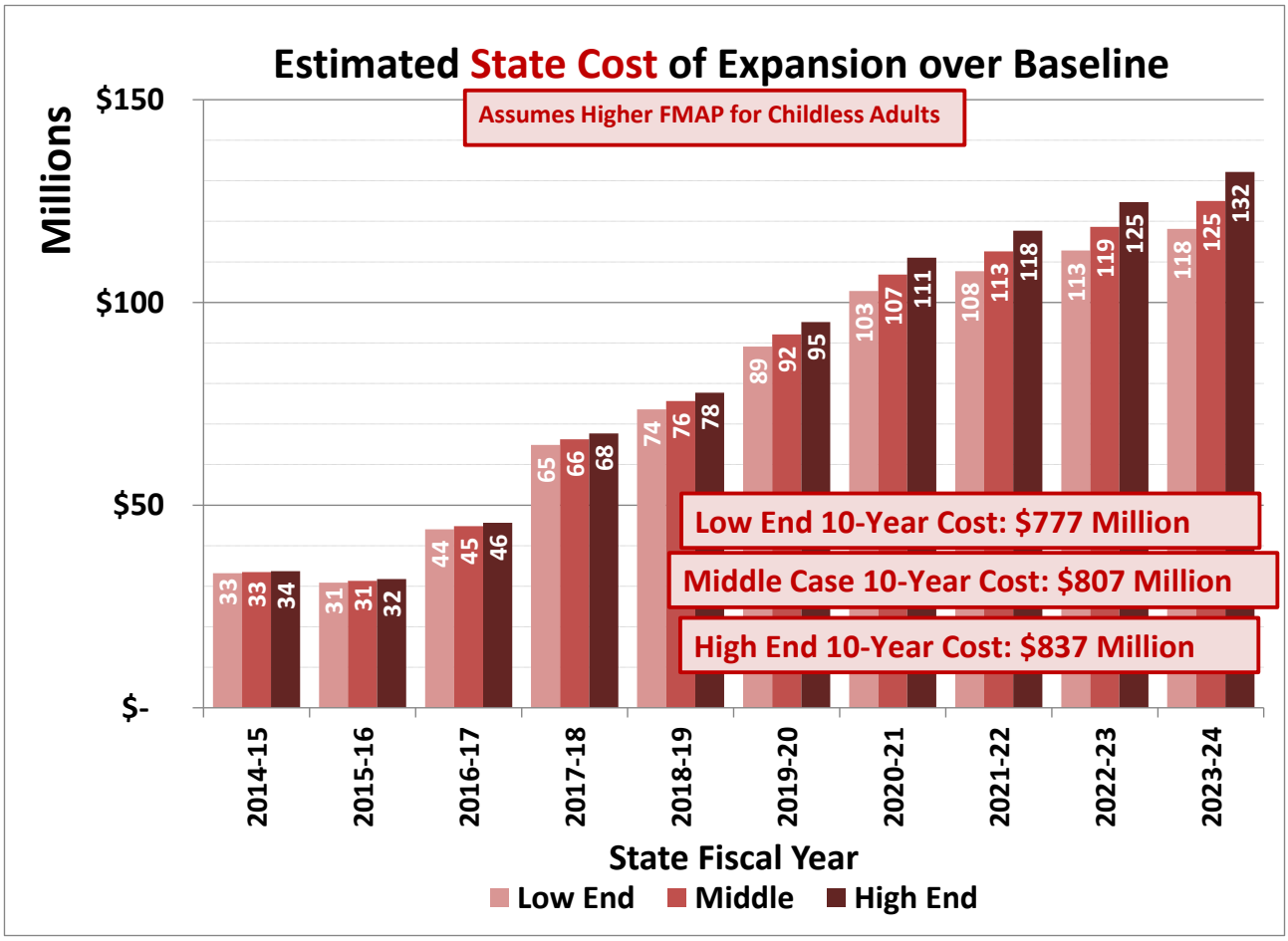

Figure 52: Poverty Risk Factor Impact on State Cost of Expansion Relative to the Baseline

Poverty Growth Risk Factor Impact on State Cost of Expansion relative to the Baseline: This chart provides a graphic presentation on how the state costs of the Expansion Scenario relative to the Baseline can vary based on the potential variability in poverty growth rates. (See **Figure 52.)**

PMPM Risk Factor

The second risk factor being considered is the PMPM growth factor. The middle value was based on computations by the USDHHS Office of the Actuary. The low-end value assumes that costs would grow by a full percentage point below that calculation. However, Maine's fee reimbursement is one of the lowest in the nation compared to private reimbursement rates, which indicates there may be upward pressure to increase the rates. The high-end value is based on historic inflation for medical services in New England states, as measured by the Consumer Price Index. **Figures 53, 54, and 55** summarize potential factors and results.

Summary Box 1		
PMPM Growth Risk Factor		
Low End	**Middle**	**High End**
1.90%	2.90%	3.90%

Figure 53: PMPM Growth Risk Factor

Summary Box 2								
PMPM Risk Factor Changes to Assumed Middle Values								
Scenario and Program Metric		**Middle**	**Low End**			**High End**		
		Result	**Result**	**Difference**	**%**	**Result**	**Difference**	**%**
Baseline	Enrollment in SFY 2023-24	406,100	406,100	0	0.0%	406,100	0	0.0%
	Percent of Population on MaineCare in SFY 2023-24	29.0%	29.0%	0.0%		29.0%	0.0%	
	10 Year Total Cost (Millions $)	36,274	33,997	(2,277)	-6.3%	38,714	2,440	6.7%
	10 Year State Cost (Millions $)	14,522	13,594	(928)	-6.4%	15,517	995	6.8%
Expansion	Enrollment in SFY 2023-24	530,200	530,200	0	0.0%	530,200	0	0.0%
	Percent of Population on MaineCare in SFY 2023-24	37.9%	37.9%	0.0%		37.9%	0.0%	
	10 Year Total Cost (Millions $)	43,653	40,901	(2,752)	-6.3%	46,603	2,949	6.8%
	10 Year State Cost (Millions $)	15,329	14,345	(984)	-6.4%	16,384	1,055	6.9%

Figure 54: PMPM Risk Factor to Assumed Middle Values

Summary Box 3							
Expansion Impact of PMPM Risk Factors							
Scenario and Program Metric		**Low End**		**Middle**		**High End**	
		Increase	**%**	**Increase**	**%**	**Increase**	**%**
Impact to Baseline	Additional Enrollment in SFY 2023-24	124,100	30.6%	124,100	30.6%	124,100	30.6%
	Additional % of Population on MaineCare in SFY 2023-24	8.9%		8.9%		8.9%	
	Additional 10 Year Total Cost (Millions $)	6,904	20.3%	7,379	20.3%	7,889	20.4%
	Additional 10 Year State Cost (Millions $)	750	5.5%	807	5.6%	867	5.6%

Figure 55: Expansion Impact of PMPM Risk Factors

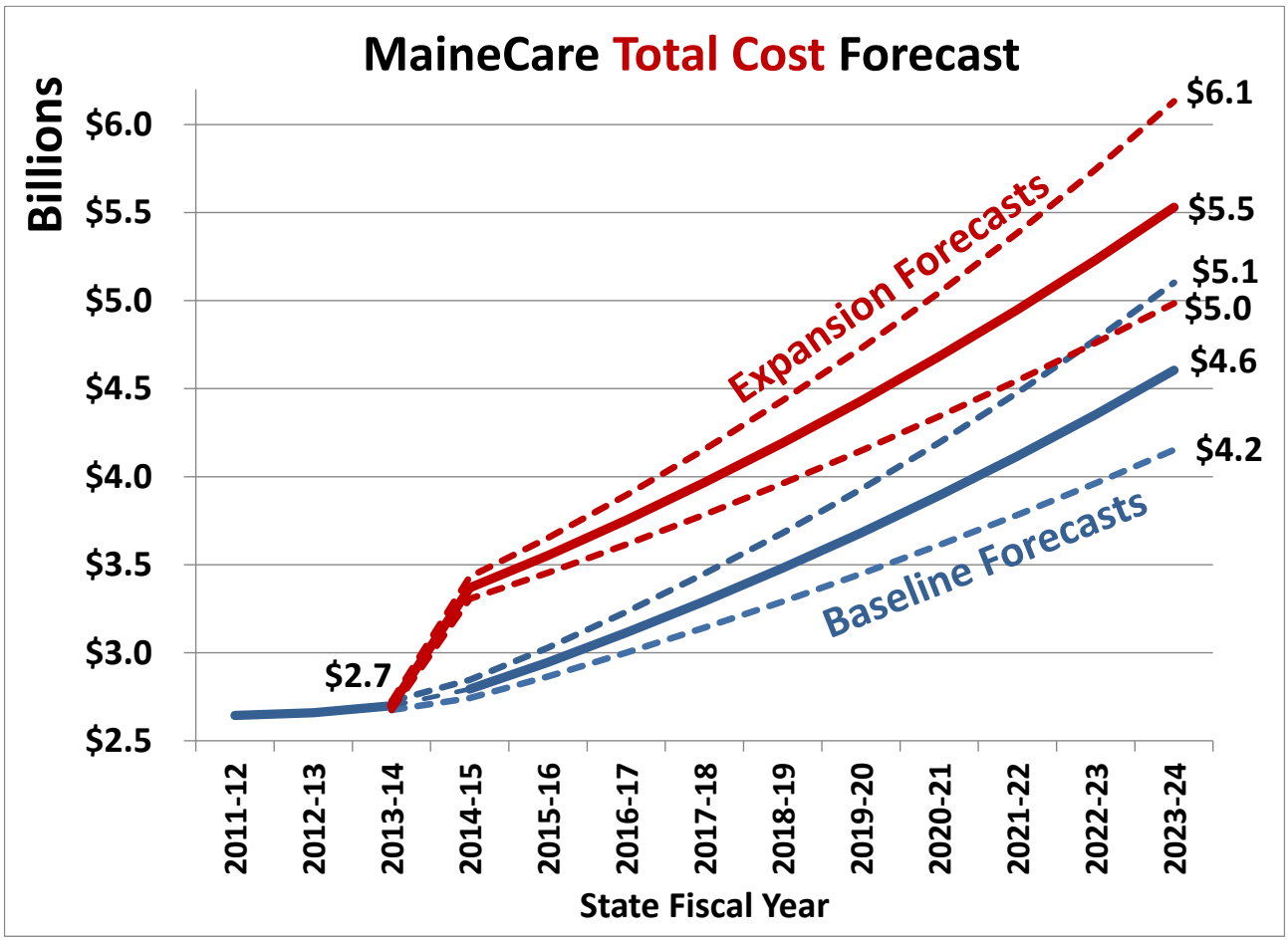

Figure 56: PMPM Risk Factor Impact on Total Cost of MaineCare

PMPM Risk Factor Impact on Total Cost of MaineCare: This chart provides a graphic presentation on how the total costs can vary based on the potential variability in PMPM growth rates. (See **Figure 56**.)

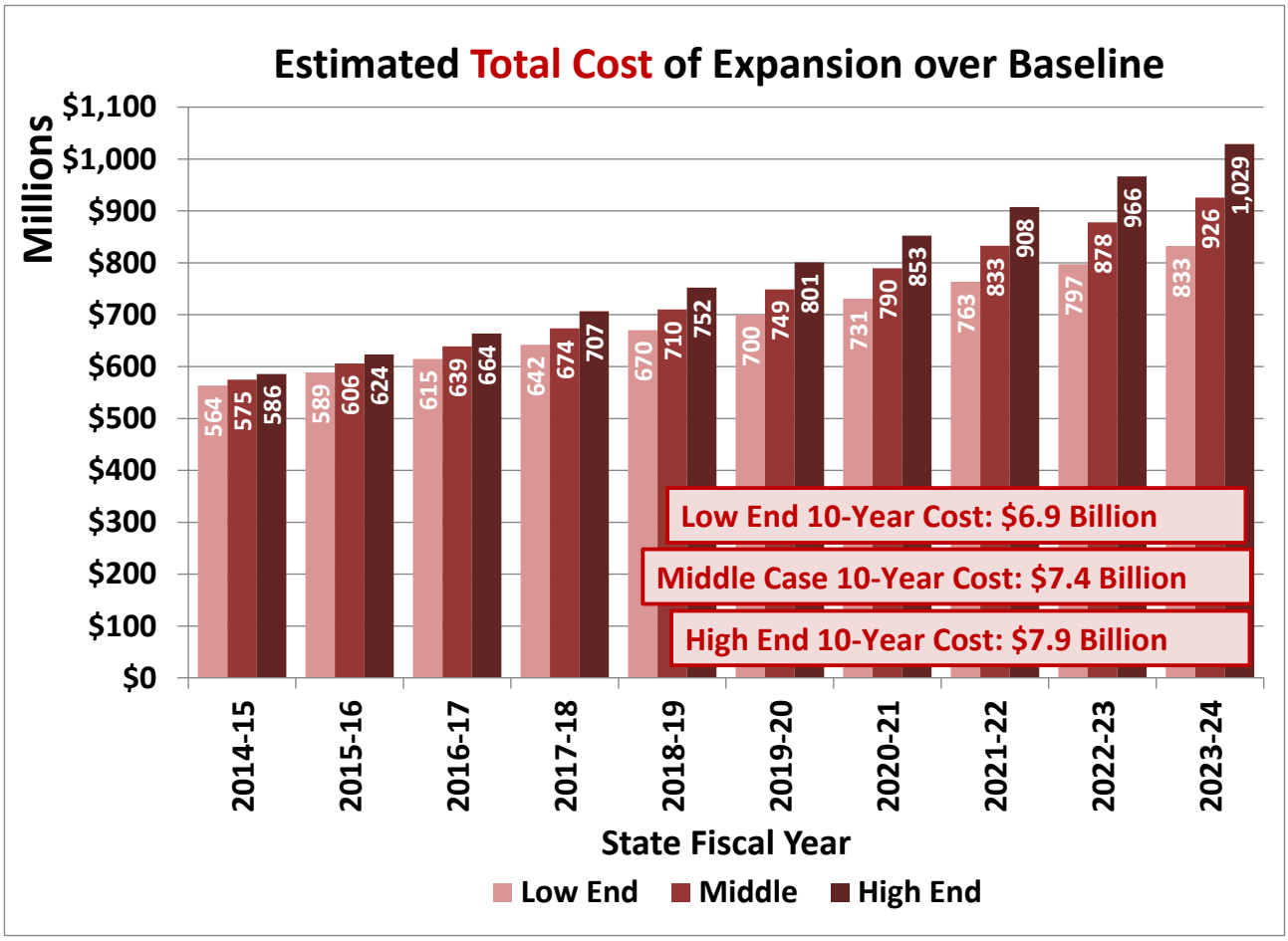

Figure 57: PMPM Risk Factor Impact on Total Cost of Expansion Relative to the Baseline

PMPM Risk Factor Impact on Total Cost of Expansion Relative to the Baseline: This chart provides a graphic presentation on how the total costs of the Expansion Scenario relative the Baseline can vary based on the potential variability in PMPM growth rates. (See **Figure 57**.)

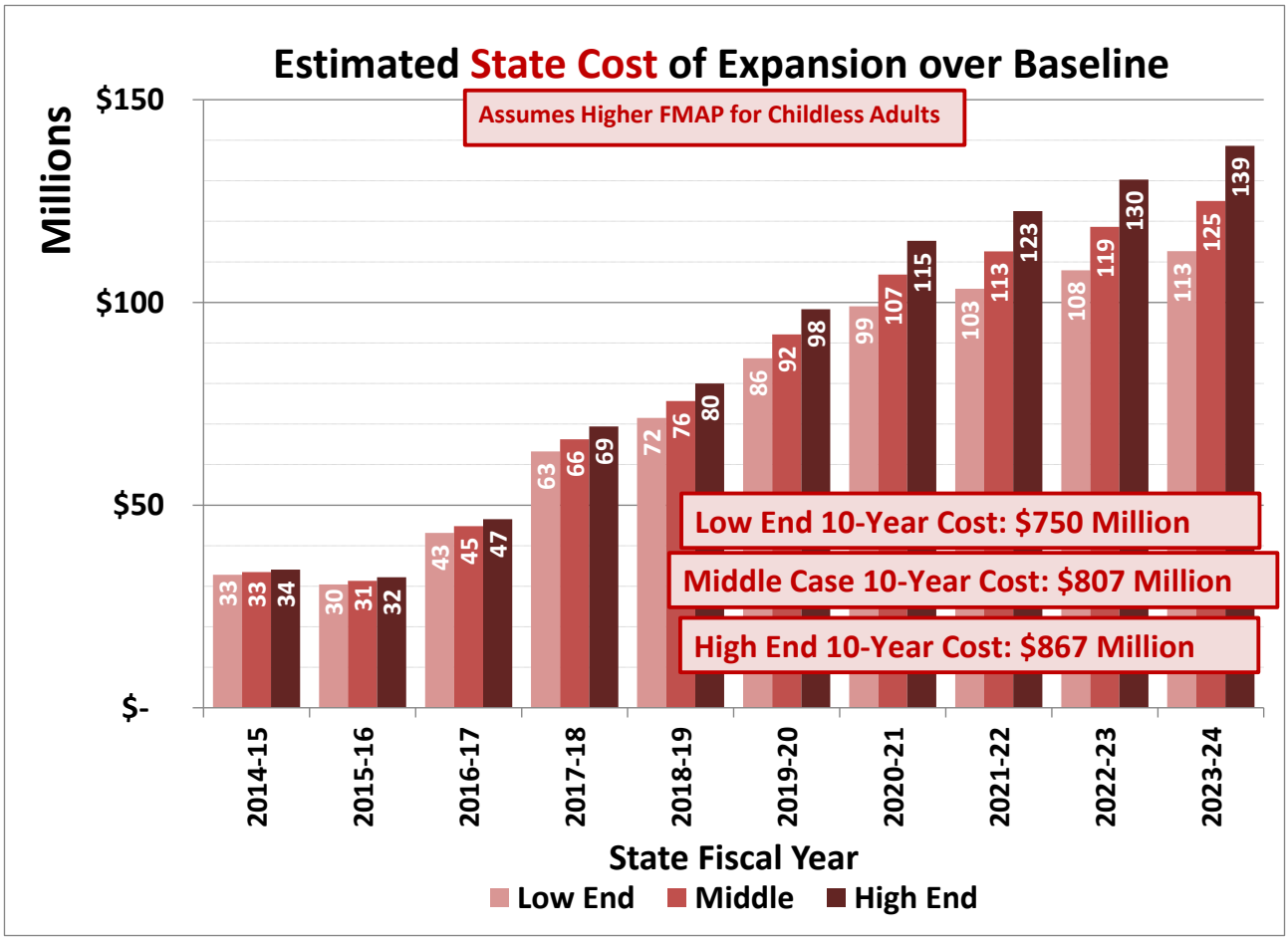

Figure 58: PMPM Risk Factor Impact on State Cost of Expansion Relative to the Baseline

PMPM Risk Factor Impact on State Cost of Expansion Relative to the Baseline: This chart provides a graphic presentation on how the state costs of the Expansion Scenario relative to the Baseline can vary based on the potential variability in PMPM growth rates. (See **Figure 58**).

Private Drop Risk Factor

The third risk factor considered is the number of persons with incomes below the ACA thresholds currently covered by health insurance who would become eligible for MaineCare if they would lose or voluntarily drop their private healthcare coverage. The percentages in **Figure 59** are the factors used to determine the number of those persons who would ultimately sign up for MaineCare. The methodology for how these factors were chosen is discussed in more detail in **Appendix A. Figures 60, and 61** summarize potential factors and results.

Summary Box 1			
Dropped Private Insurance Risk Factor			
Coverage Type	**Low End**	**Middle**	**High End**
Non-group	24.0%	30.8%	54.0%
Employer-based	80.2%	95.0%	98.0%

Figure 59: Dropped Private Insurance Risk Factor

Summary Box 2								
Private Drop Risk Factor Changes to Assumed Middle Values								
Scenario and Program Metric		**Middle**	**Low End**			**High End**		
		Result	**Result**	**Difference**	**%**	**Result**	**Difference**	**%**
Baseline	Enrollment in SFY 2023-24	406,100	406,100	0	0.0%	406,100	0	0.0%
	Percent of Population on MaineCare in SFY 2023-24	29.0%	29.0%	0.0%		29.0%	0.0%	
	10 Year Total Cost (Millions $)	36,274	36,274	-	0.0%	36,274	-	0.0%
	10 Year State Cost (Millions $)	14,522	14,522	-	0.0%	14,522	-	0.0%
Expansion	Enrollment in SFY 2023-24	530,200	522,100	-8,100	-1.5%	550,300	20,100	3.8%
	Percent of Population on MaineCare in SFY 2023-24	37.9%	37.3%	-0.6%		39.4%	1.4%	
	10 Year Total Cost (Millions $)	43,653	43,172	(481)	-1.1%	44,797	1,144	2.6%
	10 Year State Cost (Millions $)	15,329	15,286	(43)	-0.3%	15,442	113	0.7%

Figure 60: Private Drop Risk Factor Changes to Assumed Middle Values

Summary Box 3							
Expansion Impact of Private Drop Risk Factors							
Scenario and Program Metric		**Low End**		**Middle**		**High End**	
		Increase	**%**	**Increase**	**%**	**Increase**	**%**
Impact to Baseline	Additional Enrollment in SFY 2023-24	116,000	28.6%	124,100	30.6%	144,200	35.5%
	Additional % of Population on MaineCare in SFY 2023-24	8.3%		8.9%		10.3%	
	Additional 10 Year Total Cost (Millions $)	6,898	19.0%	7,379	20.3%	8,523	23.5%
	Additional 10 Year State Cost (Millions $)	764	5.3%	807	5.6%	920	6.3%

Figure 61: Expansion Impact of Private Drop Risk Factors

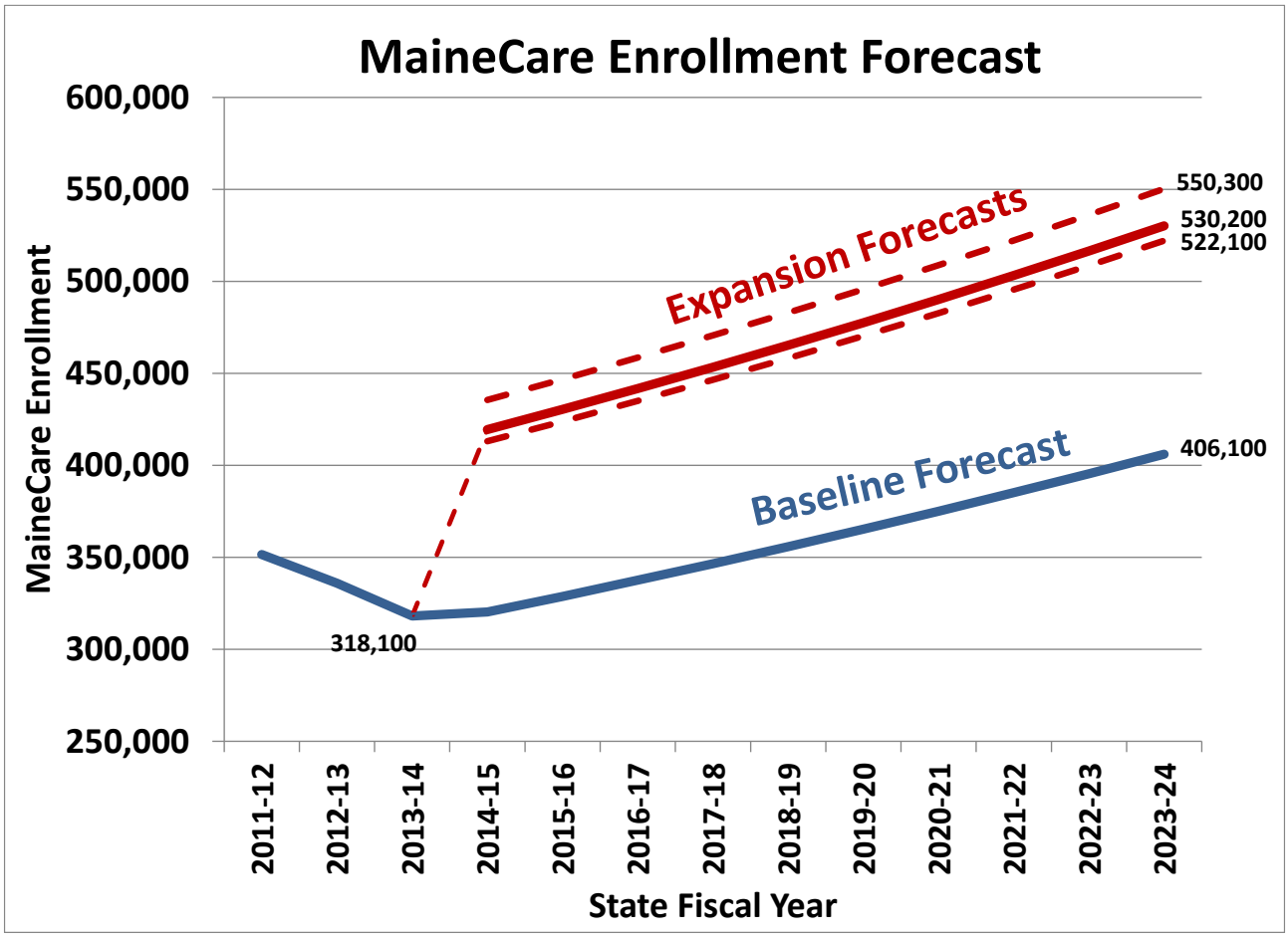

Figure 62: Private Drop Risk Factor Impact on Enrollment

Private Drop Risk Factor Impact on Enrollment: Figure 62 shows the impact on enrollment based on factors estimating the number of persons under 138% of FPL who would lose or voluntarily drop private insurance and consequently enroll in MaineCare.

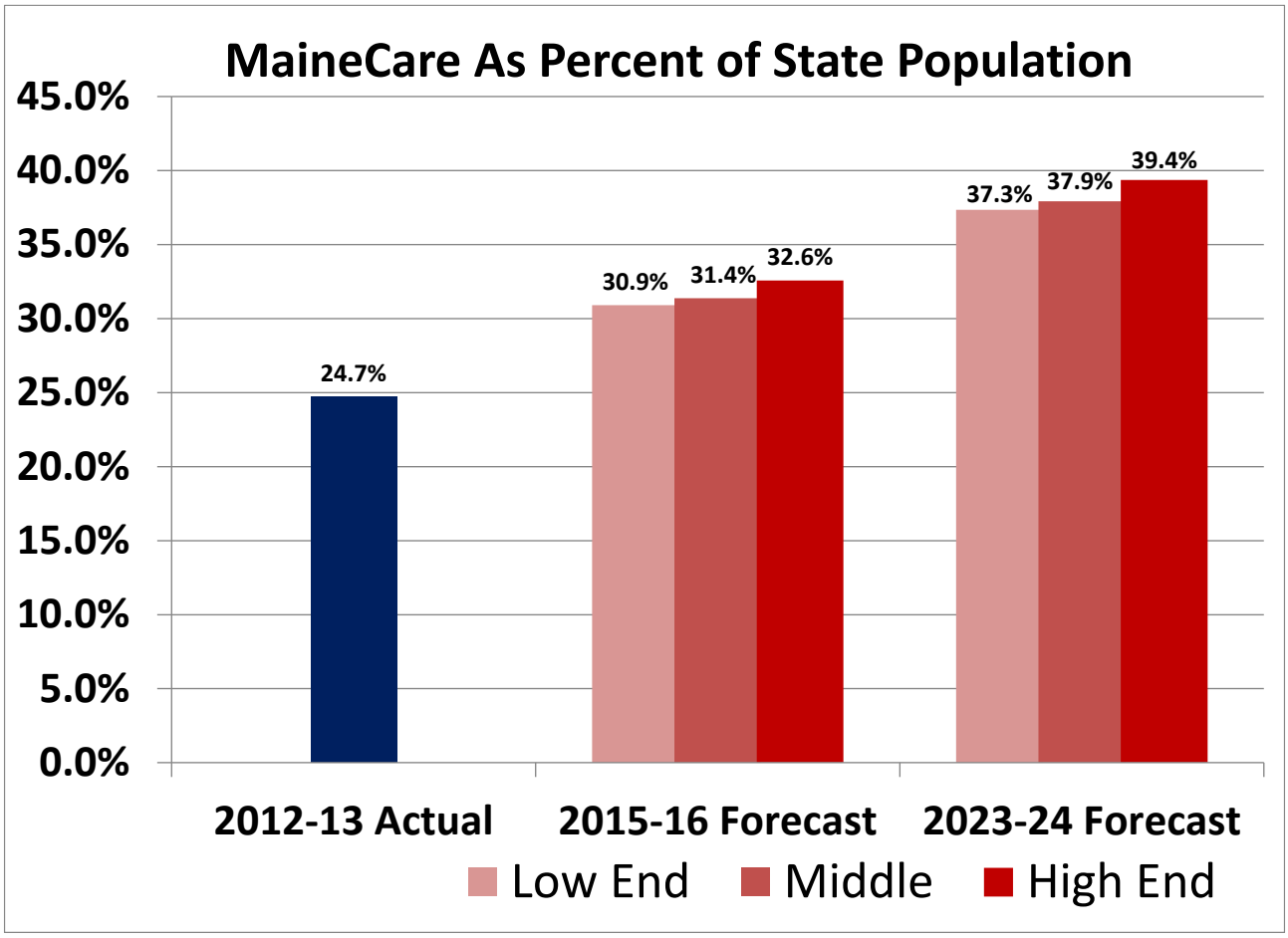

Figure 63: Private Drop Risk Factor Impact on MaineCare as a Percent of State Population

Private Drop Risk Factor Impact on MaineCare as a Percent of State Population: **Figure 63** shows the impact on the percent of persons enrolled in MaineCare as a percentage of the overall population based on factors estimating the number of persons under 138% of FPL who would lose or voluntarily drop private insurance and consequently enroll in MaineCare.

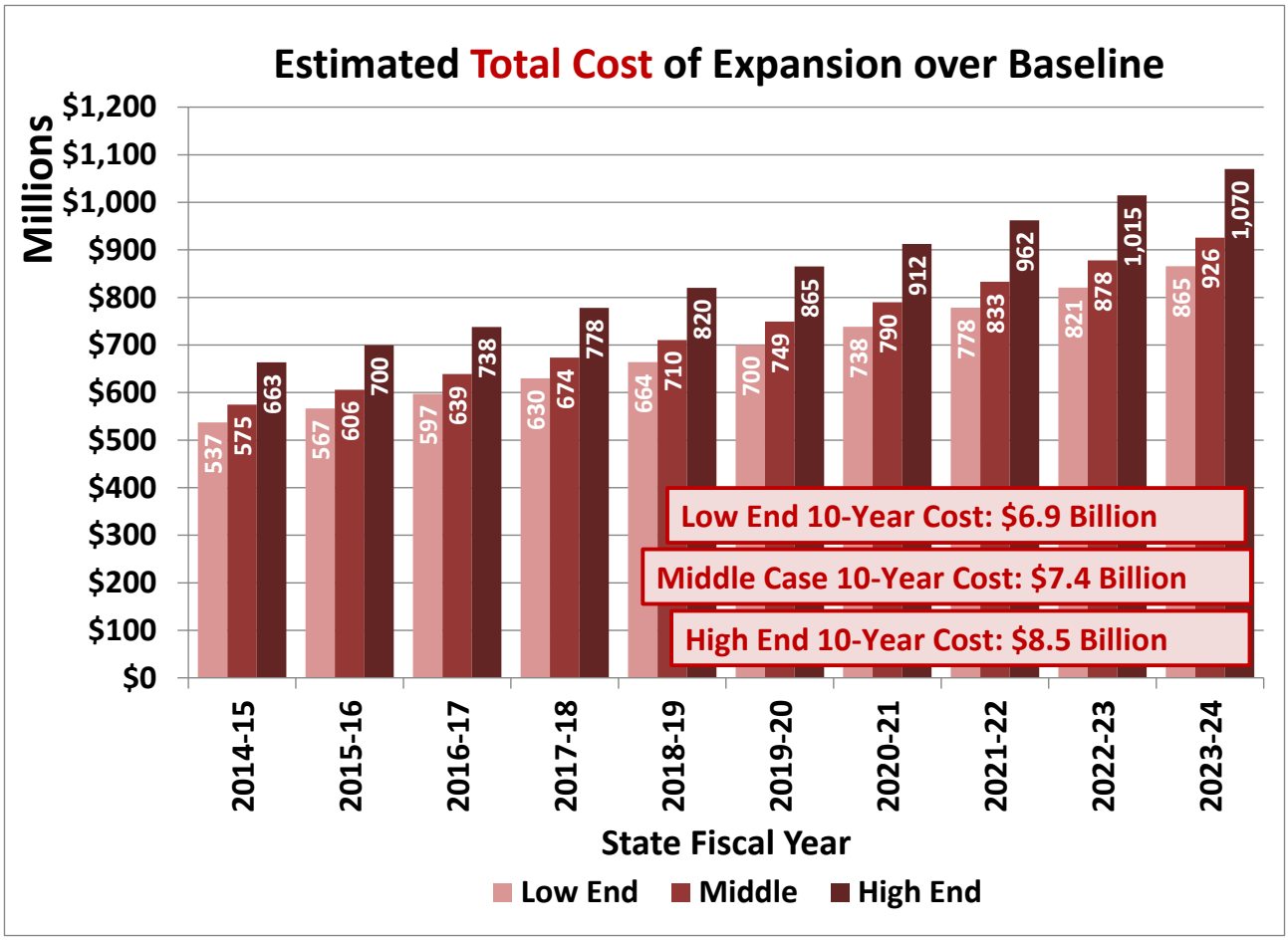

Figure 64: Private Drop Risk Factor Impact on Total Cost of MaineCare Relative to the Baseline

Private Drop Risk Factor Impact on Total Cost of MaineCare Relative to the Baseline: This chart shows how total costs of the Expansion Scenario relative to the Baseline can vary based on the potential variability in the private drop rates. (See **Figure 64**.)

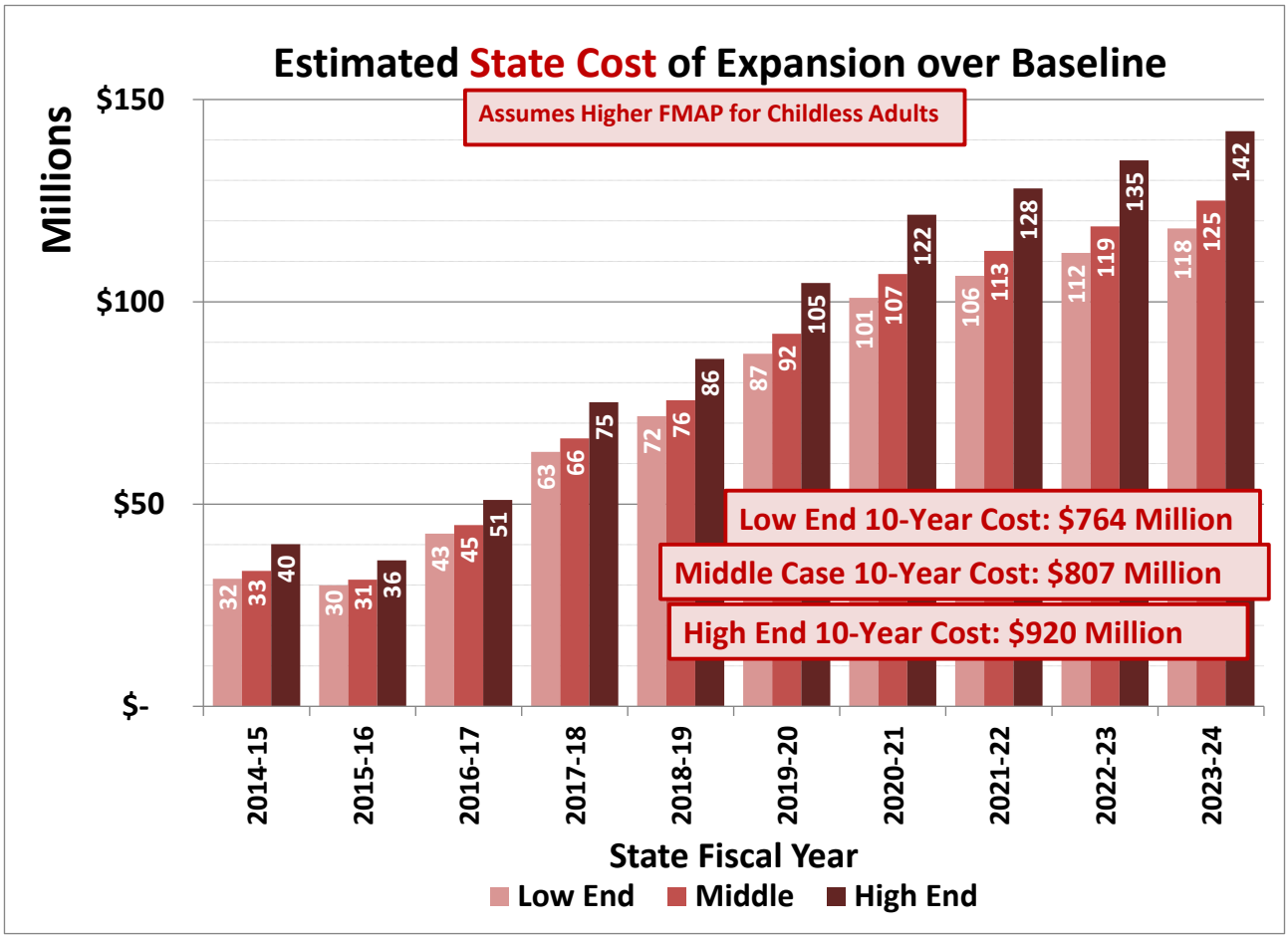

Figure 65: Private Drop Risk Factor Impact on State Cost of Expansion Relative to Baseline

Private Drop Risk Factor Impact on State Cost of Expansion Relative to the Baseline: Figure 65 shows the impact on the state cost of the Expansion Scenario relative to the Baseline based on the number of persons under 138% of FPL who would lose or voluntarily drop private insurance and subsequently enroll in MaineCare.

FMAP Risk Factor

FMAP continues to be a risk factor. The low-end values assume that beginning in SFY 2016-17 Maine would receive the highest regular FMAP rate Maine had received in the past twenty years plus the enhanced FMAP rates per the ACA. The high-end value assumes that the fiscal crisis of the federal government causes Congress to cap FMAP rates beginning in SFY 2016-17 to be equivalent to Maine's current regular FMAP across all groups, thus negating any enhanced rates. **Figures 66, 67, and 68** summarize potential factors and results.

Summary Box 1			
FMAP Risk Factor Rates in the Out Years			
FMAP Category	**Low End**	**Middle**	**High End**
Regular	66.58%	61.55%	61.55%
CHIP	96.09%	96.09%	61.55%
Enhanced	90.00%	90.00%	61.55%

Figure 67: FMAP Risk Factors

Summary Box 2								
FMAP Risk Factor Changes to Assumed Middle Values								
Scenario and Program Metric		**Middle**	**Low End**			**High End**		
		Result	**Result**	**Difference**	**%**	**Result**	**Difference**	**%**
Baseline	Enrollment in SFY 2023-24	406,100	406,100	0	0.0%	406,100	0	0.0%
	Percent of Population on MaineCare in SFY 2023-24	29.0%	29.0%	0.0%		29.0%	0.0%	
	10 Year Total Cost (Millions $)	36,274	36,086	(188)	-0.5%	36,297	23	0.1%
	10 Year State Cost (Millions $)	14,522	12,963	(1,559)	-10.7%	14,760	237	1.6%
Expansion	Enrollment in SFY 2023-24	530,200	530,200	0	0.0%	530,200	0	0.0%
	Percent of Population on MaineCare in SFY 2023-24	37.9%	37.9%	0.0%		37.9%	0.0%	
	10 Year Total Cost (Millions $)	43,653	43,465	(188)	-0.4%	43,676	23	0.1%
	10 Year State Cost (Millions $)	15,329	13,729	(1,600)	-10.4%	17,208	1,879	12.3%

Figure 66: FMAP Risk Factor Changes to Assumed of Middle Values

Summary Box 3							
Expansion Impact of FMAP Risk Factors							
Scenario and Program Metric		**Low End**		**Middle**		**High End**	
		Increase	**%**	**Increase**	**%**	**Increase**	**%**
Impact to Baseline	Additional Enrollment in SFY 2023-24	124,100	30.6%	124,100	30.6%	124,100	30.6%
	Additional % of Population on MaineCare in SFY 2023-24	8.9%		8.9%		8.9%	
	Additional 10 Year Total Cost (Millions $)	7,379	20.4%	7,379	20.3%	7,379	20.3%
	Additional 10 Year State Cost (Millions $)	766	5.9%	807	5.6%	2,448	16.6%

Figure 68: Expansion Impact of FMAP Risk Factors

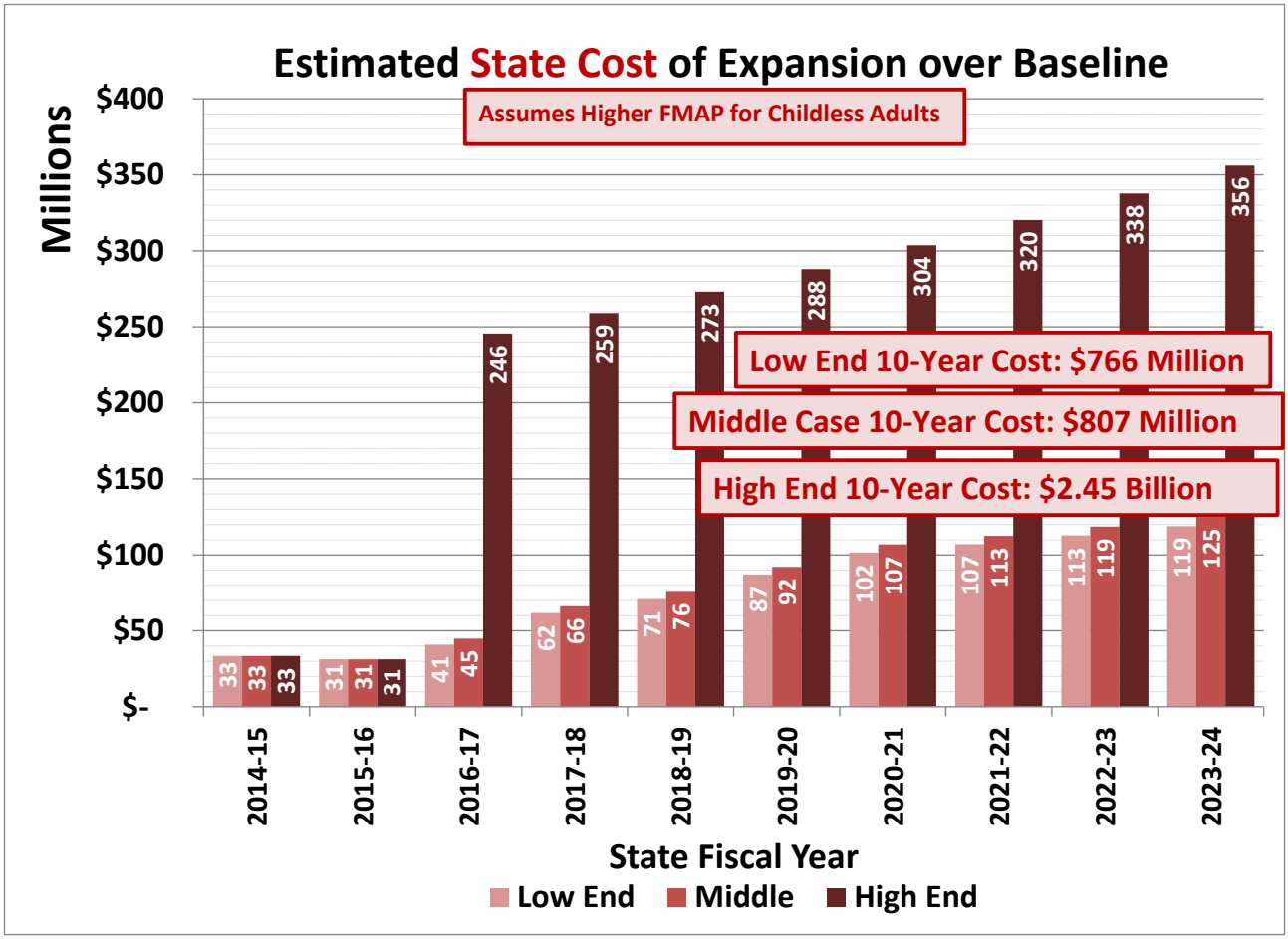

Figure 69: FMAP Risk Factor Impact on State Cost of Expansion Relative to the Baseline

FMAP Risk Factor Impact on State Cost of Expansion Relative to the Baseline: **Figure 69** summarizes the state cost based on the FMAP risks.

3 out of 4 Best Case / 3 out of 4 Worst Case Scenarios

The 3 out of 4 best case scenario and 3 out of 4 worst case scenario assume that three of the four risk factors occur for each the low-end and high-end scenarios. **Figure 70** summarizes the risk factors assumed by these scenarios. **Figures 71 and 72** summarize potential factors and results.

Summary Box 1		
Best Case/Worst Case Scenarios Three out of Four Come True		
Risk Factor	**Best Case**	**Worst Case**
Poverty Growth	Considered	Least Likely
PMPM	Considered	Considered
Private Drop	Considered	Considered
FMAP	Least Likely	Considered

Figure 70: 3-4 Best and 3-4 Worst Case Scenarios

The best case scenario assumes the following three risk factors: the poverty rate does not grow as rapidly as expected, the PMPM cost rises more slowly, and a smaller number of persons currently covered by private health insurance with incomes at or below 138% of FPL will lose their health coverage. The worst case scenario assumes the following three risk factors: PMPM costs rise more sharply, FMAP rates are reduced more drastically than anticipated, and a smaller number of persons currently covered by private health insurance with incomes at or below 138% of FPL will lose their health coverage.

Summary Box 2								
3-4 Best Case / 3-4 Worst Case Scenarios Risk Factor Changes to Assumed Middle Values								
Scenario and Program Metric		**Middle**	**Low End**			**High End**		
		Result	**Result**	**Difference**	**%**	**Result**	**Difference**	**%**
Baseline	Enrollment in SFY 2023-24	406,100	382,000	-24,100	-5.9%	406,100	0	0.0%
	Percent of Population on MaineCare in SFY 2023-24	29.0%	27.3%	-1.7%		29.0%	0.0%	
	10 Year Total Cost (Millions $)	36,274	32,698	(3,576)	-9.9%	38,739	2,465	6.8%
	10 Year State Cost (Millions $)	14,522	13,064	(1,458)	-10.0%	15,773	1,251	8.6%
Expansion	Enrollment in SFY 2023-24	530,200	491,500	-38,700	-7.3%	550,300	20,100	3.8%
	Percent of Population on MaineCare in SFY 2023-24	37.9%	35.2%	-2.8%		39.4%	1.4%	
	10 Year Total Cost (Millions $)	43,653	38,959	(4,694)	-10.8%	47,851	4,198	9.6%
	10 Year State Cost (Millions $)	15,329	13,749	(1,580)	-10.3%	18,818	3,489	22.8%

Figure 71: 3-4 Best and 3-4 Worst Case Risk Factor Changes to Assumed Middle Values

Summary Box 3							
Expansion Impact of 3-4 Best Case / 3-4 Worst Case Scenarios Risk Factors							
Scenario and Program Metric		**Low End**		**Middle**		**High End**	
		Increase	**%**	**Increase**	**%**	**Increase**	**%**
Impact to Baseline	Additional Enrollment in SFY 2023-24	109,500	28.7%	124,100	30.6%	144,200	35.5%
	Additional % of Population on MaineCare in SFY 2023-24	7.8%		8.9%		10.3%	
	Additional 10 Year Total Cost (Millions $)	6,261	19.1%	7,379	20.3%	9,113	23.5%
	Additional 10 Year State Cost (Millions $)	685	5.2%	807	5.6%	3,045	19.3%

Figure 72: Expansion Impact of 3-4 Best Case and 3-4 Worst Case Risk Factors

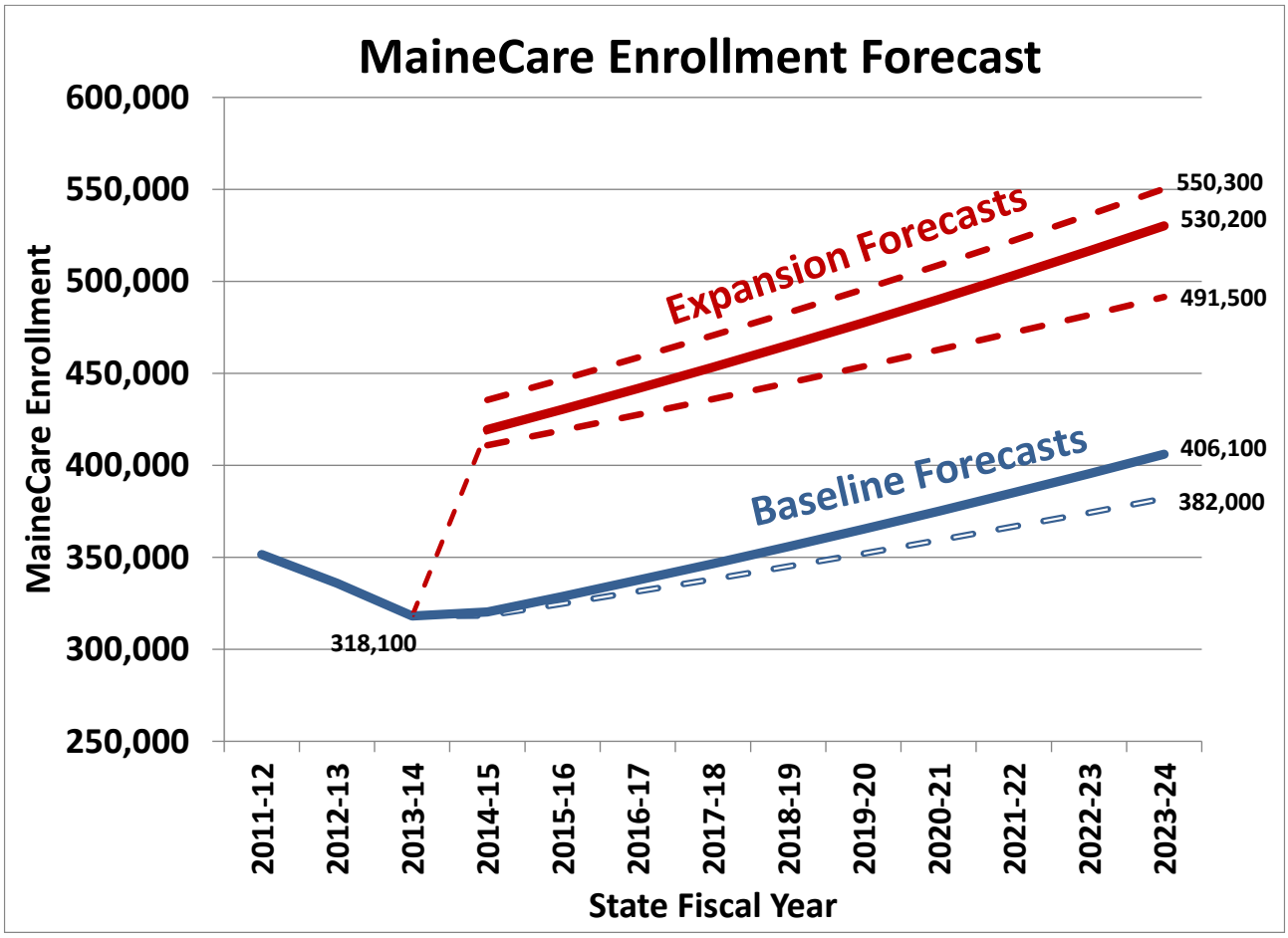

Figure 73: 3-4 Best Case / 3-4 Worst Case Risk Factor Impact on Enrollment

3-out-of-4 Best Case / 3-out-of-4 Worst Case Risk Factor Impact on Enrollment: Figure 73 shows how MaineCare enrollment would change under the best case and worst case scenarios.

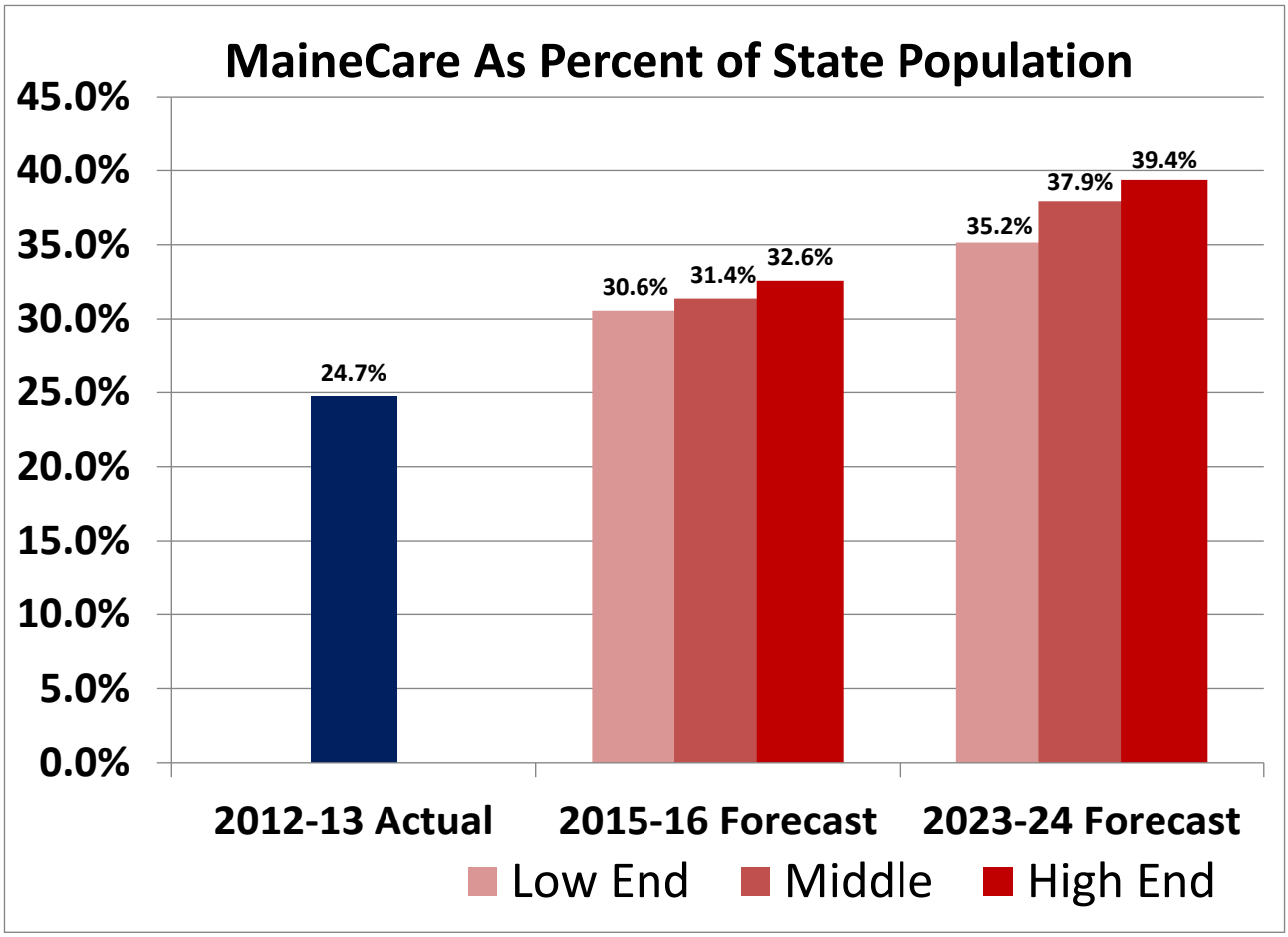

Figure 74: 3-4 Best Case / 3-4 Worst Case Risk Factor Impact on MaineCare as a Percent of State Population

3-out-of-4 Best Case / 3-out-of-4 Worst Case Risk Factor Impact on MaineCare as a Percent of State Population: Figure 74 shows how MaineCare enrollment as a percent of the overall population would change under the best case and worst case scenarios. In the best case scenario, 35.2% of the population would be on MaineCare by SFY 2023-24. In the worst case scenario, it would be 39.4%

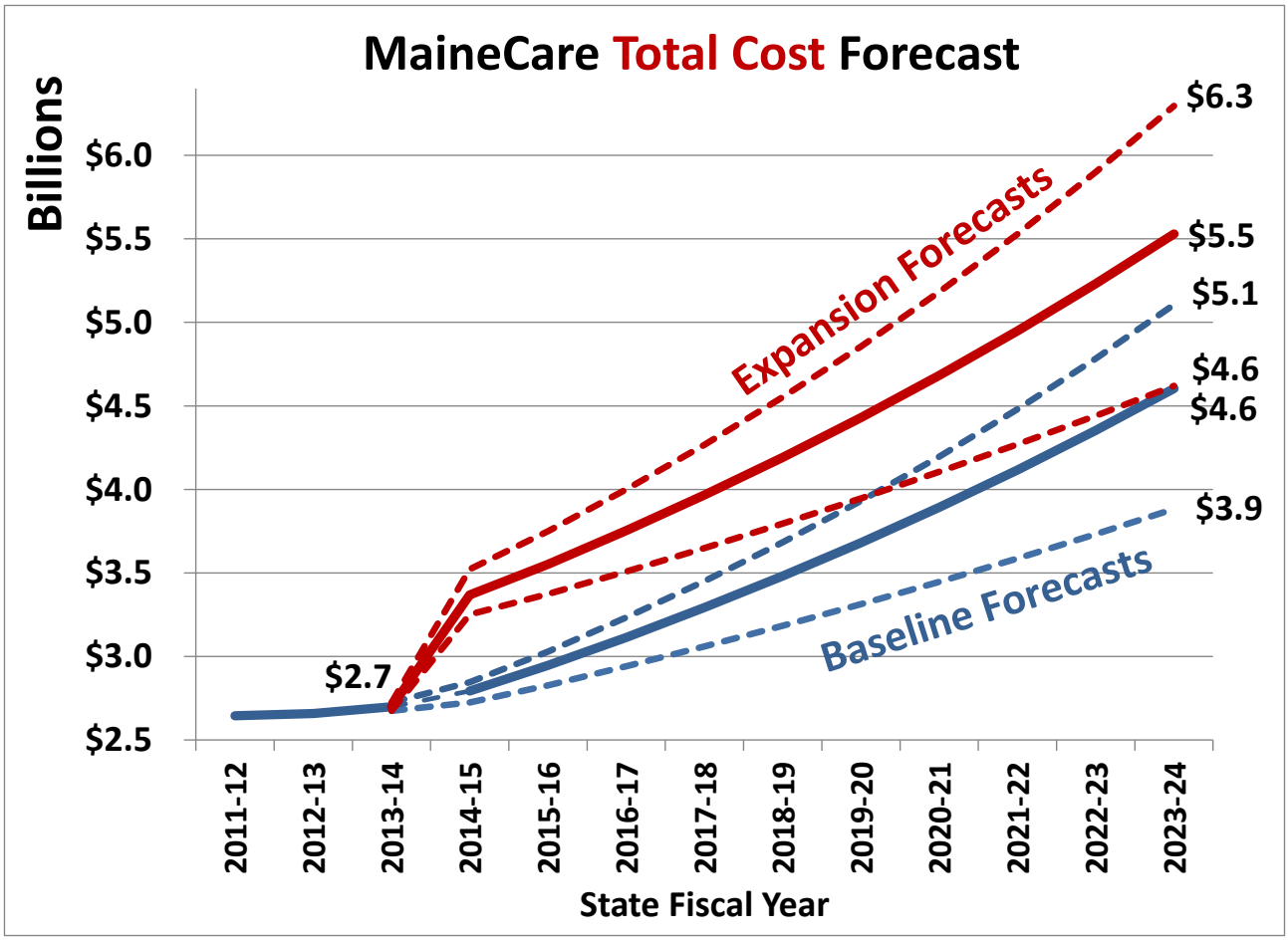

Figure 75: 3-4 Best Case / 3-4 Worst Case Risk Factor Impact on Total Costs of MaineCare

3-out-of-4 Best Case / 3-out-of-4 Worst Case Risk Factor Impact on Total Costs of MaineCare: This chart provides a graphic presentation on how the total cost can vary under the best case and worst case scenarios. (See **Figure 75**.)

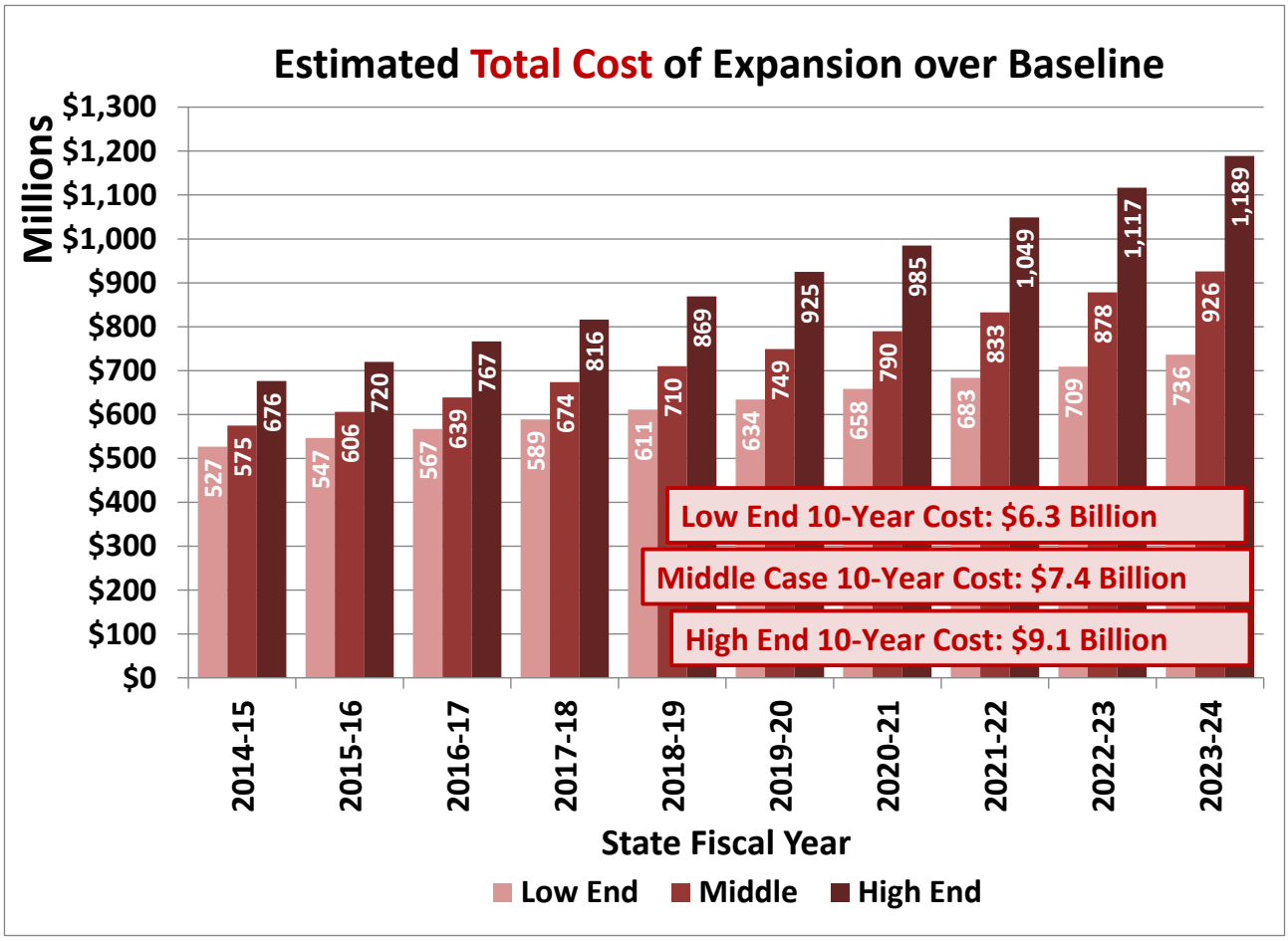

Figure 76: 3-4 Best Case / 3-4 Worst Case Risk Factor Impact on Total Cost of Expansion Relative to the Baseline

3-out-of-4 Best Case / 3-out-of-4 Worst Case Factor Impact on Total Cost of Expansion Relative to the Baseline: Figure 76 shows how total cost for MaineCare would change due to the Expansion Scenario relative to the Baseline under the best case and worst case scenarios.

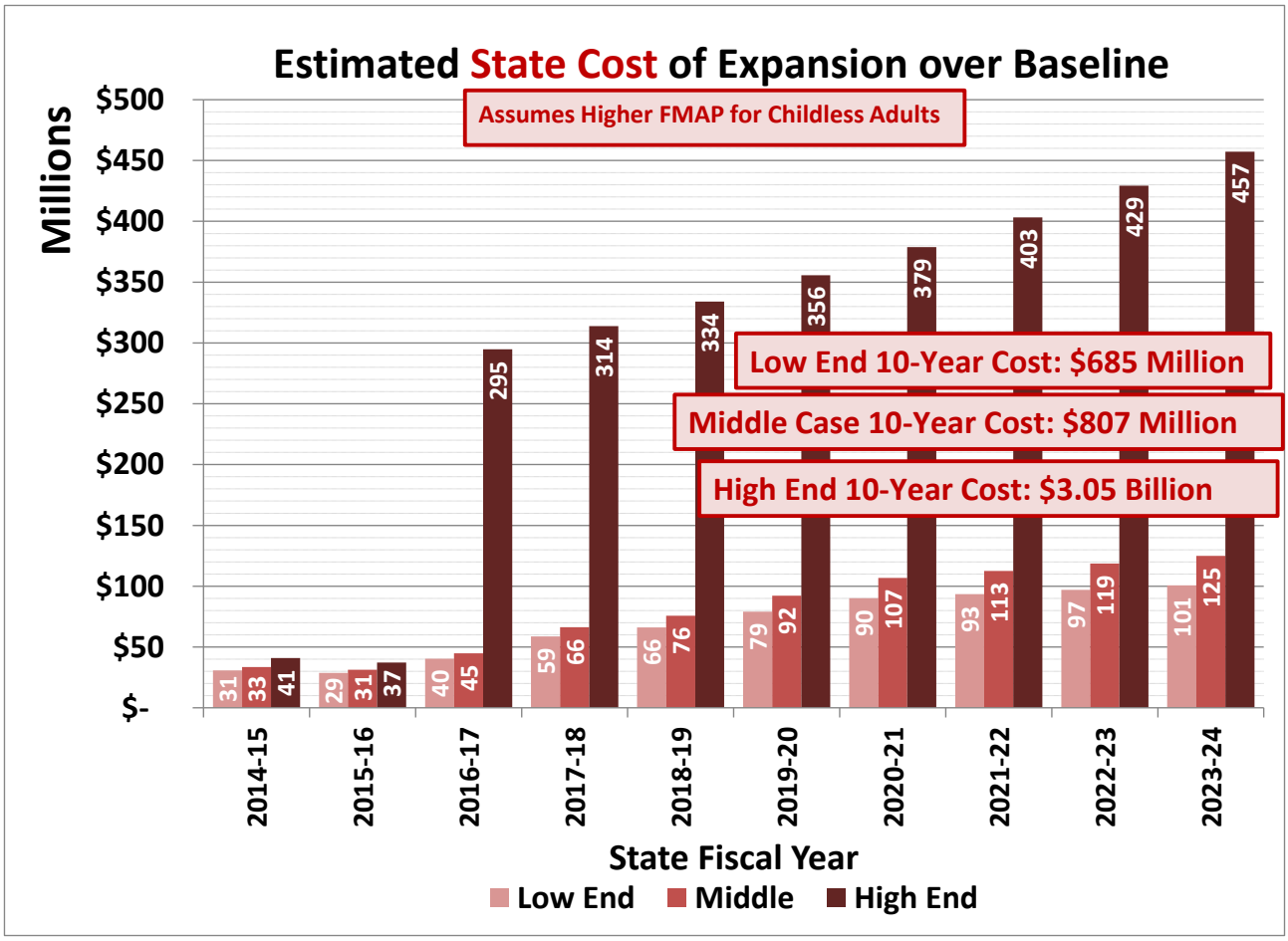

Figure 77: 3-4 Best Case / 3-4 Worst Case Risk Factor Impact on State Cost of Expansion Relative to the Baseline

3-out-of-4 Best Case / 3-out-of-4 Worst Case Risk Factor Impact on State Cost of Expansion Relative to the Baseline: Figure 77 shows how state costs of MaineCare under the Expansion Scenario relative to the Baseline would change under the best case and worst case scenarios. As can be seen they are radically different. Under the best case scenario, Maine still has a cost of $685 million over ten years. Under the worst case scenario, the cost would be $3.05 billion over ten years.

4 out of 4 Best Case / 4 out of 4 Worst Case Scenarios

The 4 out of 4 best case scenario and 4 out of 4 worst case scenario assume that all four risk factors occur for each the low-end and high-end scenarios. **Figure 78** summarizes the risk factors assumed by these scenarios. **Figures 79 and 80** summarize potential factors and results.

Summary Box 1		
Best Case/Worst Case Scenarios Four out of Four Come True		
Risk Factor	**Best Case**	**Worst Case**
Poverty Growth	Considered	Considered
PMPM	Considered	Considered
Private Drop	Considered	Considered
FMAP	Considered	Considered

Figure 78: 4-4 Best and 4-4 Worst Case Scenarios

Summary Box 2								
4-4 Best Case / 4-4 Worst Case Scenarios Risk Factor Changes to Assumed Middle Values								
Scenario and Program Metric		**Middle**	**Low End**			**High End**		
		Result	**Result**	**Difference**	**%**	**Result**	**Difference**	**%**
Baseline	Enrollment in SFY 2023-24	406,100	382,000	-24,100	-5.9%	431,900	25,800	6.4%
	Percent of Population on MaineCare in SFY 2023-24	29.0%	27.3%	-1.7%		30.9%	1.8%	
	10 Year Total Cost (Millions $)	36,274	32,531	(3,743)	-10.3%	40,341	4,067	11.2%
	10 Year State Cost (Millions $)	14,522	11,685	(2,837)	-19.5%	16,438	1,916	13.2%
Expansion	Enrollment in SFY 2023-24	530,200	491,500	-38,700	-7.3%	584,600	54,400	10.3%
	Percent of Population on MaineCare in SFY 2023-24	37.9%	35.2%	-2.8%		41.8%	3.9%	
	10 Year Total Cost (Millions $)	43,653	38,793	(4,861)	-11.1%	49,745	6,092	14.0%
	10 Year State Cost (Millions $)	15,329	12,335	(2,995)	-19.5%	19,594	4,265	27.8%

Figure 79: 4-4 Best and 4-4 Worst Case Risk Factor Changes to Assumed Middle Values

Summary Box 3							
Expansion Impact of 4-4 Best Case / 4-4 Worst Case Scenarios Risk Factors							
Scenario and Program Metric		**Low End**		**Middle**		**High End**	
		Increase	**%**	**Increase**	**%**	**Increase**	**%**
Impact to Baseline	Additional Enrollment in SFY 2023-24	109,500	28.7%	124,100	30.6%	152,700	35.4%
	Additional % of Population on MaineCare in SFY 2023-24	7.8%		8.9%		10.9%	
	Additional 10 Year Total Cost (Millions $)	6,261	19.2%	7,379	20.3%	9,404	23.3%
	Additional 10 Year State Cost (Millions $)	649	5.6%	807	5.6%	3,156	19.2%

Figure 80: Expansion Impact of 4-4 Best Case and 4-4 Worst Case Risk Factors

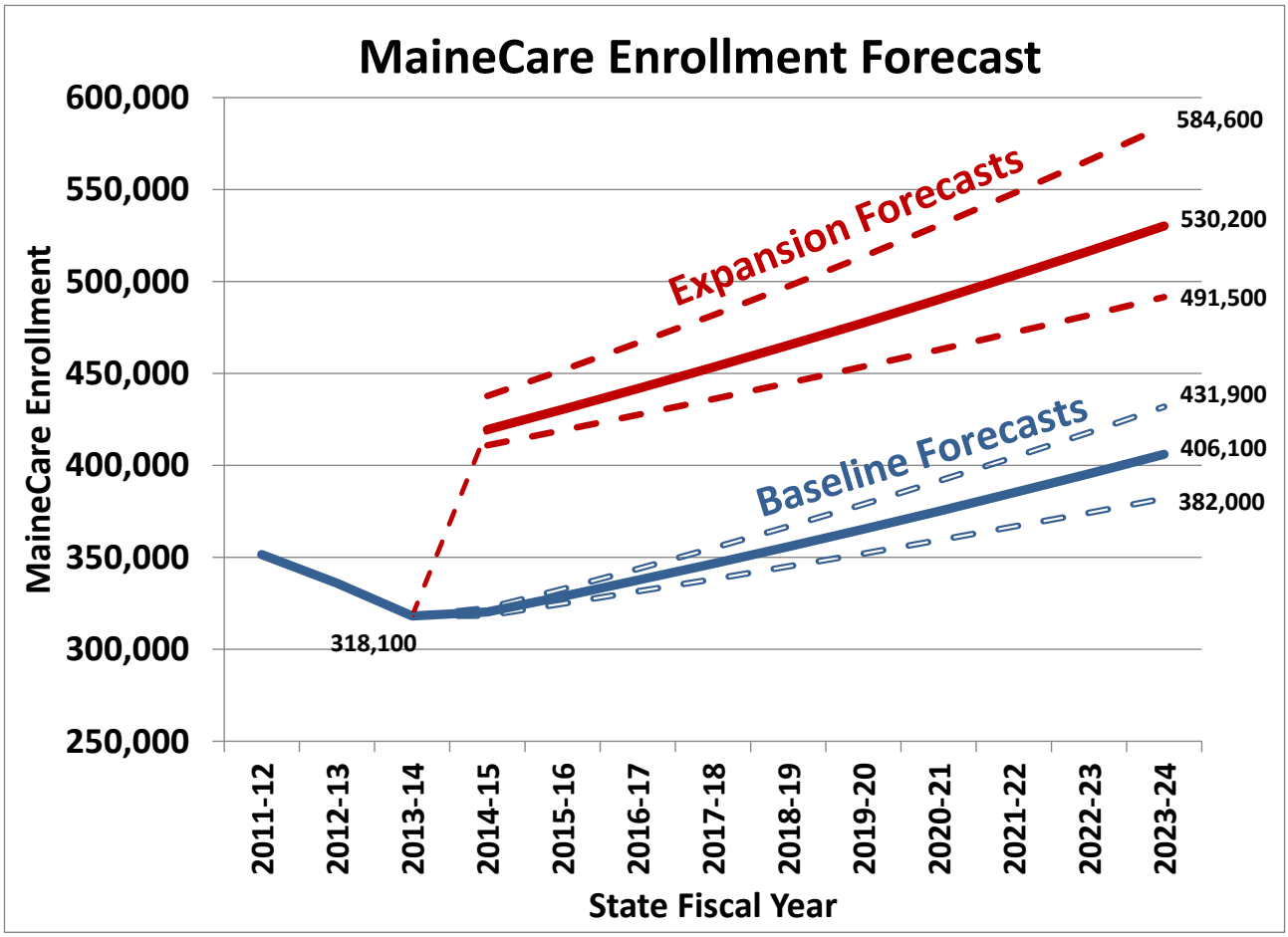

Figure 81: 4-4 Best Case / 4-4 Worst Case Risk Factor Impact on Enrollment

4-out-of-4 Best Case / 4-out-of-4 Worst Case Risk Factor Impact on Enrollment: Figure 81 shows how MaineCare enrollment would change under the best case and worst case scenarios.

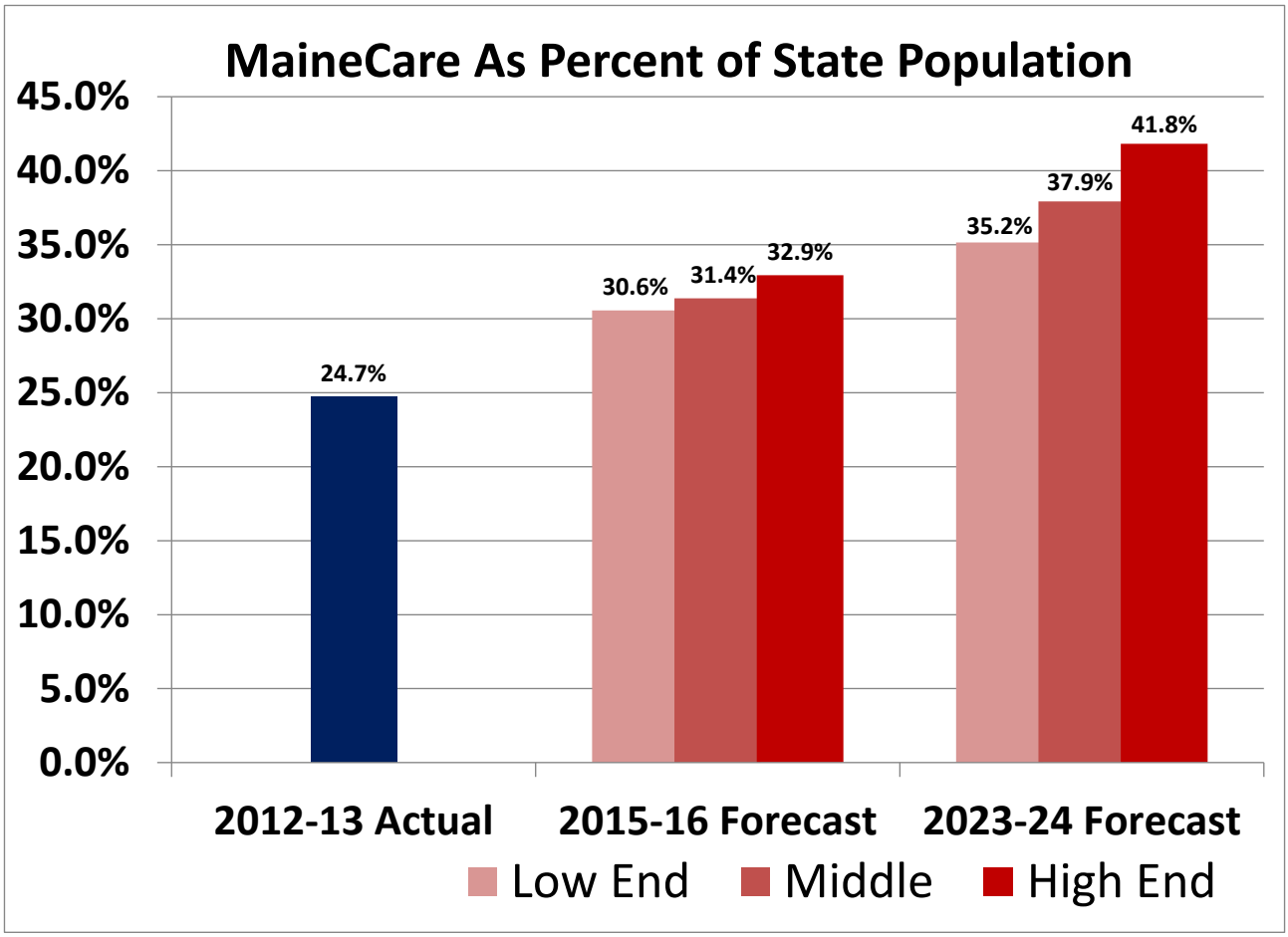

Figure 82: 4-4 Best Case / 4-4 Worst Case Risk Factor Impact on MaineCare as a Percent of State Population

4-out-of-4 Best Case / 4-out-of-4 Worst Case Risk Factor Impact on MaineCare as a Percent of State Population: Figure 82 shows how MaineCare enrollment as a percent of the overall population would change under the best case and worst case scenarios. In the best case scenario, 35.2% of the population would be on MaineCare by SFY 2023-24. In the worst case scenario, it would be 41.8%

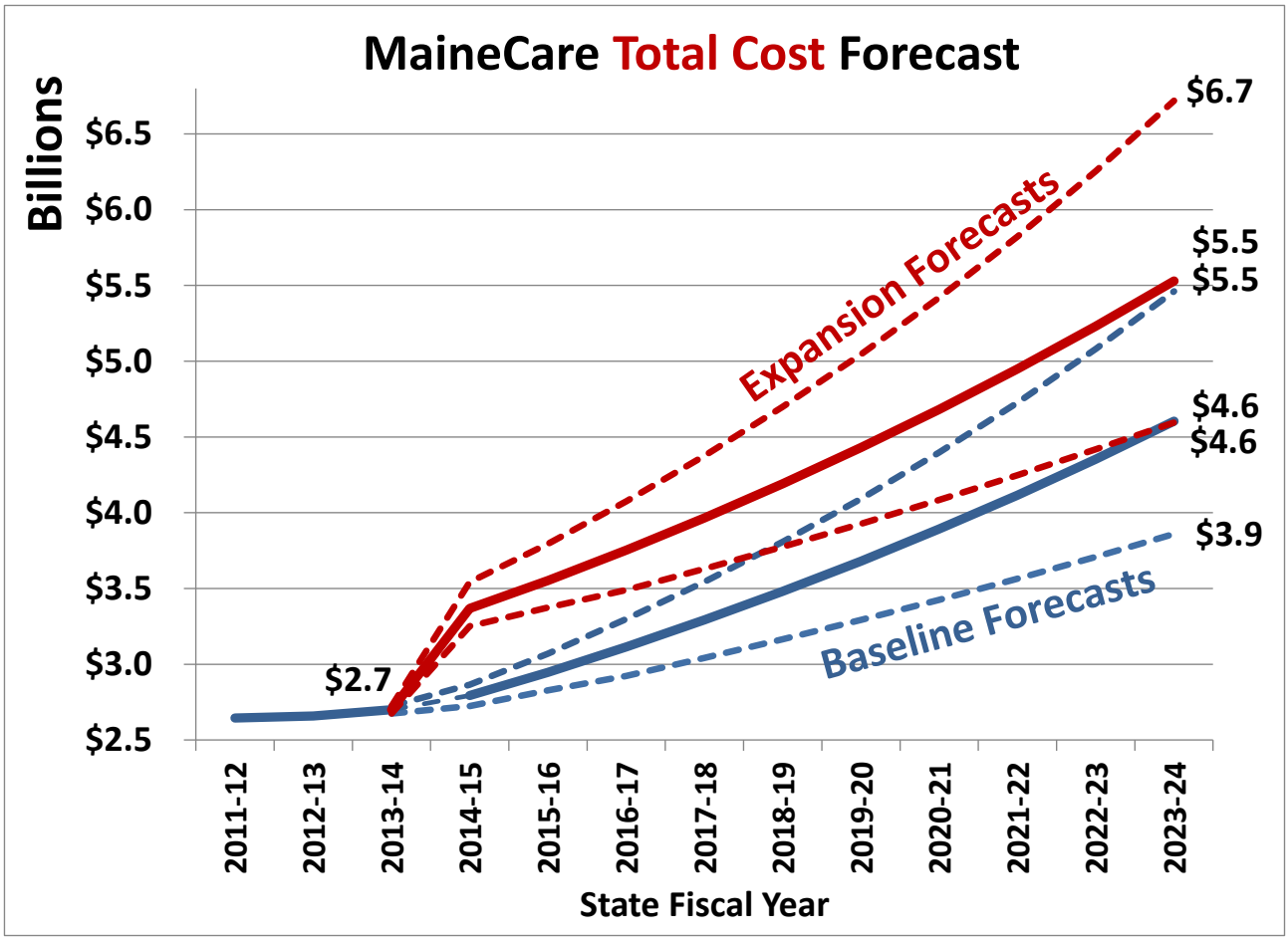

Figure 83: 4-4 Best Case / 4-4 Worst Case Risk Factor Impact on Total Costs of MaineCare

4-out-of-4 Best Case / 4-out-of-4 Worst Case Risk Factor Impact on Total Costs of MaineCare: This chart provides a graphic presentation on how the total cost can vary under the best case and worst case scenarios. (See **Figure 83**.)

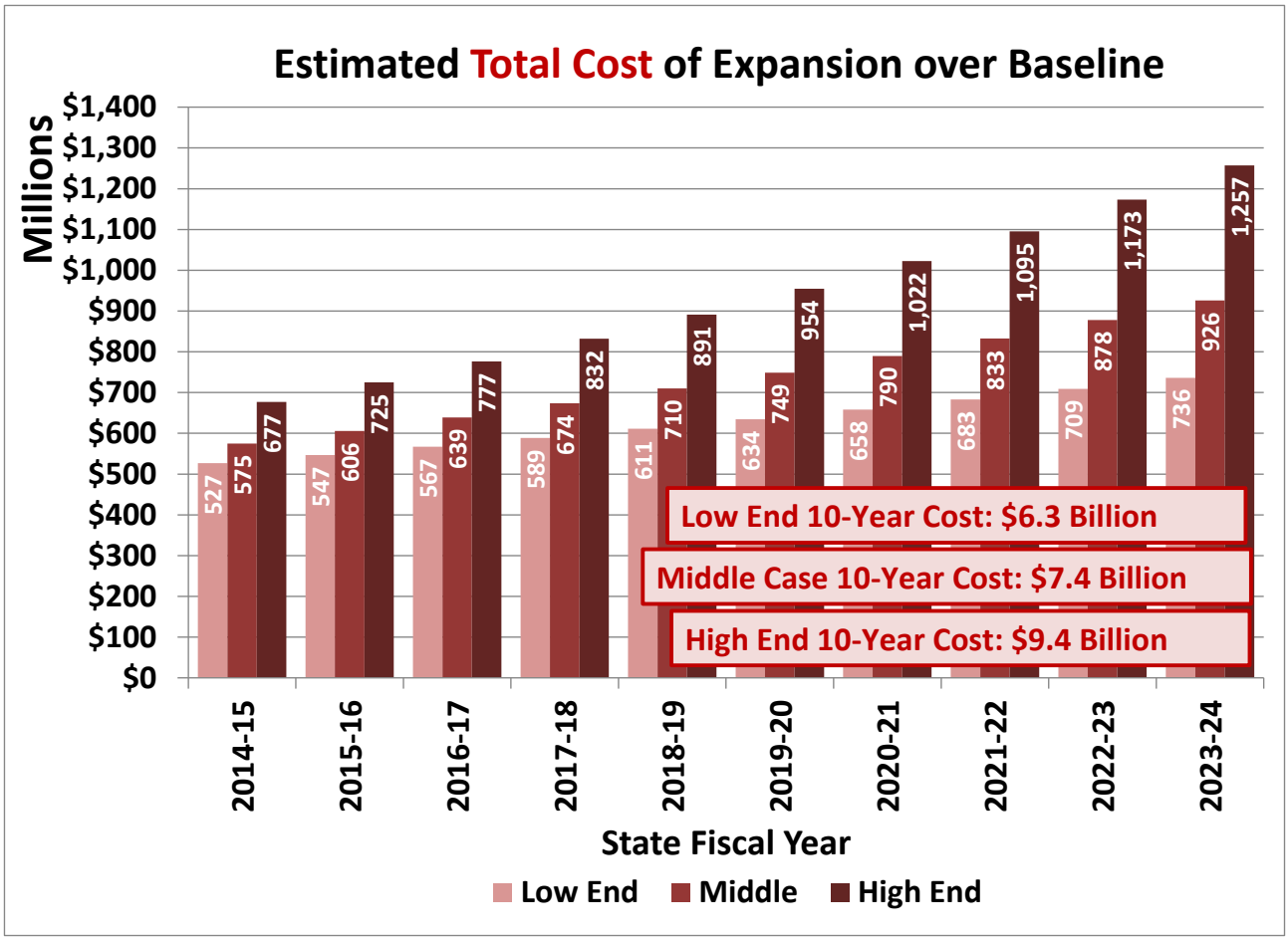

Figure 84: 4-4 Best Case / 4-4 Worst Case Risk Factor Impact on Total Cost of Expansion Relative to the Baseline

4-out-of-4 Best Case / 4-out-of-4 Worst Case Risk Factor Impact on Total Cost of Expansion Relative to the Baseline: Figure 84 shows how total cost for MaineCare would change due to the Expansion Scenario relative to the Baseline under the best case and worst case scenarios.

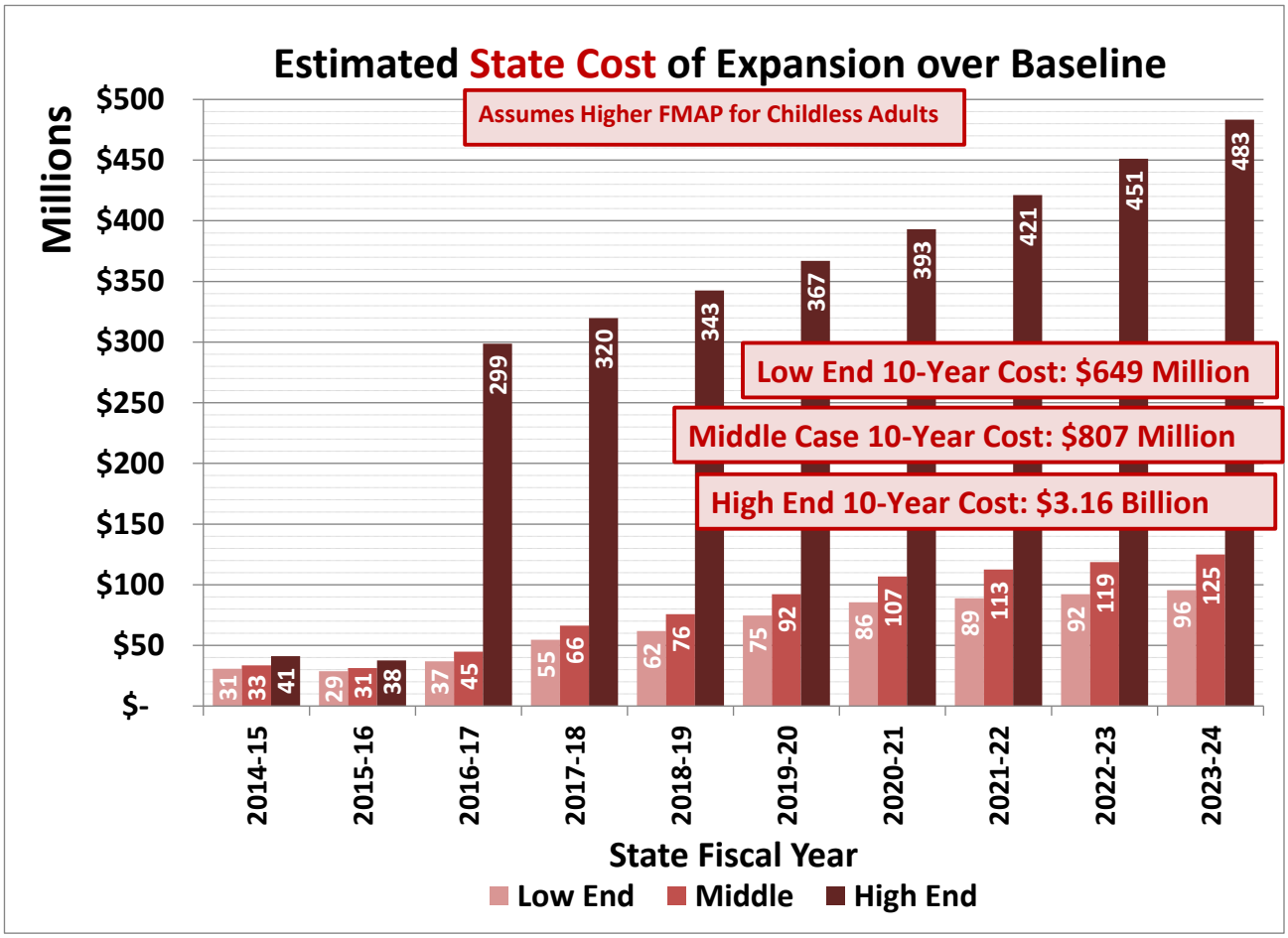

Figure 85: 4-4 Best Case / 4-4 Worst Case Risk Factor Impact on State Cost of Expansion Relative to the Baseline

4-out-of-4 Best Case / 4-out-of-4 Worst Case Risk Factor Impact on State Cost of Expansion Relative to the Baseline: Figure 85 shows how state costs of MaineCare under the Expansion Scenario relative to the Baseline would change under the best case and worst case scenarios. As can be seen they are radically different. Under the best case scenario, Maine still has a cost of $649 million over ten years. Under the worst case scenario, the cost would be $3.16 billion over ten years.

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Section VII: Conclusion and Next Steps

As this report reveals, expanding the Medicaid program in Maine involves fiscal, operational, and qualitative issues. The AG Financial Model demonstrates that it will be challenging for Maine to afford MaineCare in the future even without expansion. Given current trends, MaineCare will comprise larger shares of Maine's General Fund budgets, which will grow from 24.2% of the General Fund budget to 36.2% in ten years. The state's poverty growth rate is one causal factor driving the difference between the state cost for MaineCare and the rest-of-the-state budget. Expanding eligibility will only exacerbate the trend, whereby MaineCare will comprise 38.7% of the General Fund budget in ten years.

In addition, the risk analysis in **Section VI** shows that in the best-case scenario, i.e., if three out of four determining factors turn out to be more favorable than predicted, expansion of Medicaid eligibility would still cost Maine in state funds at least $685 million over the next ten years on top of the cost of the Baseline. In total funds (all state and federal funds), the best-case scenario for expansion would have a ten-year cost of $6.3 billion, and 35.2% of the state population would be enrolled in MaineCare. However, the worst-case scenario, i.e., if three out of four determining factors turn out to be less favorable than predicted, would cost the state $3.05 billion over the next ten years on top of the cost of the Baseline. In total funds, the worst-case scenario for expansion would have a ten-year cost of $9.1 billion, and 39.4% of the state population would be enrolled in MaineCare. If four out of four factors turn out to be favorable, the ten-year state costs would be $649 million, the ten-year total costs would be $6.3 billion, and 25.2% of the state population would be enrolled in MaineCare. If four out of four factors turn out to be less favorable, the ten-year state costs would be $3.16 billion, the ten-year total costs would be $9.4 billion, and 41.8% of the state population would be enrolled in MaineCare.

The qualitative issues are no less challenging. Consistent with national Medicaid trends, performance measures indicate that the quality of care provided by MaineCare does not match what is available elsewhere, including commercially available insurance. Expanding MaineCare does not address any of these quality-of-care issues; moreover, expansion may leave those losing commercial coverage with no other choice but to enroll in MaineCare. Expansion will also divert resources from addressing serious program-integrity issues to protect the program against waste, abuse, and fraud. Finally, expansion will allow those less vulnerable to access comprehensive care while doing nothing to alleviate MaineCare's current challenge to eradicate the waiting lists for the intellectually disabled and elderly populations.

The more pressing needs are restructuring and streamlining to make MaineCare more efficient and to deliver better quality outcomes. As in most states, over time, the system has been so expanded and changed in a piecemeal manner that it has become uncoordinated, difficult for many to navigate, lacking in key program-integrity safeguards, and exhibiting cost factors that exceed the growth of the rest of the General Fund budget. Expanding MaineCare at the current time will likely divert resources away from reform efforts necessary to address these pressing issues and to improve the program.

Health-care access and improved health outcomes remain a necessity. Expansion of Medicaid at the present time however, may not be the best policy choice to attain those goals. Other viable alternatives may allow Maine to improve access and quality while prioritizing needs and saving tax dollars. Consequently, Maine needs a state-based solution with flexibility from the federal government that focuses on access, transparency, quality, personal responsibility, and efficiency. That kind of alternative would likely offer executive and legislative policymakers greater budgetary certainty and allow them to focus on other fiscal and policy priorities.

Appendix A: Methodology, Assumptions, Data, and Other Technical Information

Overview

The financial model used for this study was specifically developed and customized by The Alexander Group for the State of Maine. Because each state is different, it is necessary to tailor a model to the specific demographics of a state as well as the unique characteristics of its Medicaid program. No two states are alike, and more generic models miss these nuances that produce less specific results.

There are numerous assumptions and data sources that were utilized in generating the Baseline and Expansion scenarios. This appendix summarizes the more important ones.

Population Groups

The following populations groups were identified for use in the model:

Group A

- Traditional MaineCare Major categories:
  - Aged
  - Blind/Disabled
  - Children with incomes up to 100% of FPL
  - Parents with incomes up to 100% of FPL
  - Pregnancy
  - State only
  - Other
- Children on CHIP with incomes 101% to 138% of FPL
- Children on CHIP with incomes 139% to 200% of FPL
- Parents with incomes between 101% and 138% of FPL
- Childless adults covered under the childless adult waiver
- Foster children between the ages of 19 and 25
- Medicaid Savings Plan participants, i.e., in Drugs for Elderly (DEL) program and/ or Maine Rx

Group B

- Children “woodwork effect”
- Parents “woodwork effect”

Group C

- Other childless adults not covered under the waiver with incomes up to 138% of FPL

Group D

- Children covered by private insurance with incomes up through 200% of FPL
- Parents covered by private insurance with incomes up through 138% of FPL

Group A are those categories for which MDHHS was able to produce population data from internal database systems.

Group B are the woodwork-effect populations. In these cases, population estimates were created by multiplying 2011 Current Population Survey (CPS) data estimates issued by the U.S. Census Bureau on the number of children and parents currently eligible for Medicaid but not enrolled with take-up rates of 23.4% as published by the Kaiser Family Foundation for Health Policy Analysis.[88]

Group C are adults not on the childless adult waiver and with incomes up to 138% of FPL. This estimate was derived by using data from the U.S. Census Bureau's American Community Survey for 2012, multiplied by a take-up rate of 82% pursuant to a study for the Assistant Secretary for Planning and Evaluation, USDHHS, by the RAND Corporation specifically on take-up rates for Medicaid enrollment per the ACA.[89]

Group D are those persons who are currently covered by private insurance but would lose their coverage due to the anticipated effect of employers dropping coverage, employers taking other action encouraging low-wage employees to sign up for Medicaid as opposed to employer-provided insurance, insurers cancelling policies due to requirements of the ACA, or other voluntary actions by the policyholders. Estimates of children, childless adults, and parents at incomes below 138% of FPL, in addition to children from 139% to 200% of FPL, were derived from CPS data, which were further broken down into subcategories of those with employer health insurance coverage and non-group coverage. The two different take-up rates applied were 95% for those with non-group coverage and 30.8% for those with employer-based coverage. The assumption of 95% comes from the USDHHS Office of the Actuary.[90] The ACA was designed in a manner to increase insurance costs for this segment of the population, which has the effect of making many of these policies illegal, causing them to be withdrawn by insurers. It is likely that most of the childless adults in this category would have their policies withdrawn and the replacement options made available to them will be significantly more expensive. With the expansion of Medicaid, it would become the logical choice to choose free coverage over non-group policies that will likely be out of their price range. Because take-up rates never equal 100%, the model assumed the USDHHS assumption of 95% for the middle value. The RAND Corporation computation of 82% was used for the low-end risk analysis. 98% was used the high-end risk analysis. The assumption of 30.8% comes from a published survey of

[88] John Holahan, Matthew Buettgens, Caitlin Carroll, and Stan Dorn, The Urban Institute, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Sponsored and published by the *Kaiser Commission on Medicaid and the Uninsured*, November 2012

[89] Ben Sommers, Rick Kronick, Kenneth Finegold, Rosa Po, Karyn Schwartz, and Sherry Glied, "Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act," *ASPE Issue Brief*, March 2012. Accessed at: http://aspe.hhs.gov/health/reports/2012/MedicaidTakeup/ib.shtml.

[90] Idem.

McKinsey & Company.[91] The proprietary research that surveyed 1,329 employers in February 2011 assessed their attitudes and plans on the ACA. One of the many findings was that 24% of employers with a low awareness of the ACA thought they might likely drop employee health coverage, 30.8% of employers with medium awareness thought they likely might, and 54% of employers with a high level of awareness thought they might likely drop. These values are used in the risk analysis In **Section VI** of this report.

It is important to note that employers can easily deploy tactics other than dropping health insurance coverage altogether to encourage their low-wage workers voluntarily drop coverage and sign up for Medicaid. Employers with more than fifty employees are required under the ACA to offer health insurance to its employees, and federal law[92] requires them to have rational policies that do not discriminate, therefore requiring them to offer health care to all employees if they offer it to some employees of the same full-time or part-time status. However, by simply requiring employees to make contributions to the cost of the premium, it can make the employer-based health insurance significantly expensive to low income employees, especially when compared to Medicaid which has no premium cost share.

Actuarial Growth Assumptions

The model used standard actuarial methodologies to forecast population growth factors. Separate growth factors were generated accounting for poverty by the following age groups: under 18, 18-64, over 65, and an overall growth factor. In addition, growth factors were calculated for the total population. The low-end and high-end values were calculated assuming a 25% variance.

Population Growth Factors			
Age Category	**Low End**	**Middle**	**High End**
Under 18	2.31%	3.08%	3.85%
18 to 64	1.86%	2.48%	3.10%
65 and over	2.71%	3.61%	4.51%
Total	2.09%	2.78%	3.48%

Figure 86: Population Growth Factors

The results of the actuarial growth factors were compared to historic MaineCare and poverty growth between two similar points along the business cycle for comparability, and they were found to be similar. **Figure 80** shows the final change in population factors used.

PMPMs

The PMPMs were calculated for each category, using data for SFY 2012-13, and was provided by the MDHHS Benefit Analytics team. **Figure 81** shows the actual PMPMs per category.

[91] *McKinsey Quarterly*., already cited.

[92] See "Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions," U.S. Department of Labor. http://www.dol.gov/ebsa/pdf/part7-1.pdf, accessed December 19, 2013.

Population groups without calculated PMPMs were matched with the PMPMs of the closest population group that had a calculated PMPM. For example, childless adults not covered by the waiver were assumed to have the same PMPM as those covered by the waiver.

Category	PMPM
Traditional Medicaid	712.23
Aged	1,526.93
Blind/Disabled	1,553.38
Children < 100% of FP	320.64
Parents < 100% of FPL	392.38
Pregnancy	912.29
State Only	1,785.96
Other Traditional	254.15
CHIP	222.04
Childless Adults (Waive	514.18
Parents to 138% of FPL	271.46
Foster Children	257.60

Figure 87: Actual PMPMs Per Category

PMPM Growth Factors

Projecting the growth rate for PMPMs is complex because so many factors come into play. Inflation specific to the health care industry influences the rise in costs. The Consumer Price index for medical care for the Boston-Brockton-Nashua, MA-NH-ME-CT area, which includes Maine, was 3.9% over the last ten years. However, Medicaid reimbursement fees are negotiated between CMS and the state and have been notoriously low, thus creating the problem of not having enough doctors willing to serve Medicaid clients. Lack of access can in turn cause political pressure to increase fees, but these efforts are constrained by the reality of limited budgets. Consequently, Medicaid fees lag inflation. However, utilization is also a cost determinant, and some Medicaid patients tend to use services more frequently or in more costly settings, such as emergency rooms. The model assumed the 2.9% factor used by the USDHHS Office of the Actuary, and is similar to national historic cost. This assumption is conservative. The low-end and high-end risk factors assumed 1.9% and 3.9%.

FMAP

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
	Available	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
Traditional Medicaid	61.81%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%
CHIP	73.27%	73.09%	90.34%	96.09%	96.09%	96.09%	96.09%	96.09%	96.09%	96.09%	96.09%
Foster Children	61.81%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%
Parents	61.81%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%	61.55%
Childless Adult (<=100% FPL)-1	80.78%	82.70%	86.54%	88.51%	89.56%	91.90%	91.50%	90.00%	90.00%	90.00%	90.00%
Childless Adult (<=100% FPL)-2	80.78%	100.00%	100.00%	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%	90.00%	90.00%
Childless Adult (101%-138%)		100.00%	100.00%	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%	90.00%	90.00%
Administration	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%
Administration (Enhanced)		90.00%	90.00%	90.00%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%	61.56%

Figure 88: Assumed FMAP Rates

FMAP rates were provided by the MDHHS Benefits Analytic team. Because these are calculated based on a federal formula whose factors vary on an annual basis and because they can change by a whim of Congress, it is difficult to forecast FMAP rates. It was assumed that FMAP rates will remain constant. The table in **Figure 82** displays the assumed rates.

Because the FMAP rate for childless adult under 100% of FPL was unavailable at the time of writing this report, the two potential FMAP rates for this category are listed as “Childless Adult (<=100% of

FPL)-1" and "Childless Adult (<=100% of FPL)-2." These different reimbursement rates only impacts state costs, not total costs. Both rates were considered in the financial model.

Disproportionate Share Hospital (DSH) Allotments

Maine's disproportionate share hospital (DSH) allotments will be reduced over time using a methodology based on state comparisons in uninsured populations and the targeting of payments to hospitals with a high volume of Medicaid patients and high volume of uncompensated care costs. CMS has not yet released revised DSH allotments at the time of the writing of this report. Maine's allotment was capped in SFY 2012-13 at $86 million, of which $50 million is used for the childless adult waiver and $36 million for the state psychiatric hospitals at Riverview and Dorothea Dix. DSH is included in the model as part of the overall budget cost to operate MaineCare, which is included in both the Baseline and the Expansion Scenario. Because the childless adult waiver expired, the assumption was to keep the value constant because no further information was available at the time to assume otherwise. The impact, however, would likely be minor compared to the other potential costs and risks identified by the model. If, for example, Maine continues to receive the $50 million, it could choose to use it for uncompensated care, which would require a match of $31.2 million at the current FMAP rate. In the Expansion Scenario, it could be assumed that the $50 million would be phased out over a number of years, resulting in a loss of $50 million in federal money but no state costs associated with that loss. It could be argued, therefore, that there is a potential state cost of $31.2 million to the state for not expanding, if the state were to receive and accept $50 million from the federal government for DSH. However, this would be a voluntary cost and also a political decision, which is beyond the scope of this study.

Administrative Costs

The model assumes administrative costs pursuant to an analysis and estimates by MDHHS. Administrative costs for the Baseline used historic experience, and after adjusting for one-time federal funds and other one-time payments, it estimated an annual growth rate of 2.46%. For the Expansion Scenario, it assumed that 97 additional personnel would be required to determine eligibility and manage the additional workload. These costs were estimated to be $7.44 million for SFY 2014-15.

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Appendix B: Key AG Team Members Who Contributed to This Report

Gary D. Alexander, J.D.

Mr. Alexander is the founder, president, and CEO of the Alexander Group. He is a nationally recognized health-care and Medicaid expert, welfare reformer, and budget specialist. For over 16 years, he has transformed underperforming state health and welfare agencies into accountable, value-oriented, and data and performance-driven systems by pioneering structural reforms and state-of-the-art technology solutions that have improved outcomes and quality, lowered health-care costs, reduced fraud and waste, re-engineered employment programs, modernized access, and eliminated budget deficits. A pragmatic and decisive leader, Alexander has a track record not only of identifying problems but also assembling the right mix of talent, policy makers, and stakeholders to generate data-driven solutions with quantifiable results to some of the most vexing challenges facing federal, state, and local governments.

Prior to founding the Alexander Group, Mr. Alexander served as Pennsylvania Governor Tom Corbett's secretary of public welfare and Governor Tom Corbett's senior health and welfare advisor from 2011 to 2013. In that dual role, he oversaw overall operations, management, and policy development for one of the largest health and welfare agencies in the nation, a department with a budget of $27.5 billion, 6 hospitals, 5 state intermediate facilities, 94 offices, 16,500 employees, and 2.2 million public-assistance recipients.

Upon arrival in Pennsylvania, Mr. Alexander faced double-digit growth, an uncoordinated service structure, and a fragmented organization. To fix these problems, he crafted and implemented a cutting-edge plan to eradicate fraud and waste called the *Enterprise-wide Program Integrity and Improvement Initiative.* This program-integrity initiative has been lauded by Medicaid and welfare-reform experts and earned the department a national innovation award for Excellence and Best Practice from the Council of State Governments.

Prior to his tenure in the Keystone State, Mr. Alexander created and implemented similar reforms as Rhode Island's secretary of health and human services and human-services director from 2006 to 2011. He is the author and architect of the 2009 landmark Rhode Island Global Medicaid Waiver that, for the first time, delivered unprecedented flexibility to a state to redesign its Medicaid program. Relieving the state of burdensome federal mandates and requirements, this groundbreaking reform improved care quality, outcomes and access, lowered public costs, created more choices for recipients—including more appropriate care settings—and properly aligned services and benefits. The waiver's long-term care redesign is also being used as a model of reform around the nation. In its first two years, the waiver not only saved approximately $100 million but also kept total Medicaid spending at billions of dollars below the agreed-upon spending limit. To this day, the waiver continues to help Rhode Island solve budget deficits and improve quality. By improving quality, choice and access for recipients and introducing accountability into Medicaid, Alexander's initiative has been cited as a model of entitlement reform, particularly Medicaid and health care reform by various experts and publications, including *The Wall Street Journal* and the *Providence Journal*.

Mr. Alexander has worked on both sides of the aisle and has a reputation for reaching consensus to solve complex problems. Consequently, members of congress, elected officials, and policy makers consistently

seek his advice on entitlement reform. He holds a Bachelor of Arts degree from Northeastern University and a Juris Doctor (J.D.) from Suffolk University School of Law.

Erik D. Randolph

Mr. Randolph spent 28 years of his professional career in government, including 21 years with experience in fiscal analysis of legislation and government programs that involved determining fiscal impacts, forecasting costs and revenues, budgeting, and working with financial and economic models. He began his career as a program evaluator with the U.S. General Accounting Office, which was renamed the Government Accountability Office in 2004. He then worked five years for two different states in the fields of economic development and science and technology policy. Afterwards, he achieved the position of senior analyst for Chairman Dwight Evans (D) of the Committee on Appropriations, Pennsylvania House of Representatives. He also spent two years as a special policy and fiscal assistant advising Mr. Alexander when he served as Secretary of Public Welfare for Pennsylvania Governor Tom Corbett (R). He has taught principles of economics for 17 years. He has a Master of Science degree from Rensselaer Polytechnic Institute and two Bachelor degrees from the Pennsylvania State University.

Murray M. Blitzer

Mr. Blitzer possesses over 30 years of experience in public administration and finance with a specialty in Medicaid and human services. He was the Chief Financial Officer for the Rhode Island Department of Human Services, overseeing a $1.5 billion budget and over 1,000 employees. He also served in the Rhode Island Legislature as Deputy to the Senate Fiscal Officer. In the Senate, as an advisor to the Majority Leader, he implemented a budget hearing and review process that allowed the membership equal participation in formulating policy. Murray began his career in the Rhode Island State Budget Office where he designed and implemented the structure for the state's Consensus Medical Assistance and Caseload Estimating Conference, applying professional forecasting tools to over $2 billion in health care and welfare spending. Throughout his public career Murray has successfully worked with private entities to reduce the cost of government and deliver services that have had a positive impact on the lives of many consumers. Murray holds a Bachelor of Science Degree in Resource Technology and Economics from the University of Rhode Island.

Jennifer M. Wier

Ms. Wier, C.P.A., has more than 17 years of experience. She has expertise in Medicaid and is also extremely knowledgeable about information systems, systems modeling, and data mining. Ms. Wier has spent the past five years dedicated solely to Medicaid assisting in the analysis of the program from both quantitative and qualitative perspectives. She has audited both financial and policy components and is well versed in federal regulations as they pertain to the program. She has assisted in the drafting of legislation affecting several components of the Arkansas Medicaid program, including the creation of the Office of Medicaid Inspector General for the State of Arkansas as well as legislation affecting provider enrollment. For the past five years as a member of the Division of Arkansas Legislative Audit, she has been responsible for reporting on all Medicaid and human service programs of interest to the General Assembly and has acted as an independent liaison between the legislators and the program administrators. She has a Bachelor of Science in Accounting

from the University of Arkansas at Little Rock and is a member of the Arkansas Society of Professional Accountants and the Arkansas Information System Audit and Control Association.

Kevin K. Gabriel

Mr. Gabriel is an actuary and has 30 years of experience and has worked in the healthcare and employee benefits areas for over 20 years. He began his career with a national writer of group health insurance and later moved to a pair of major reinsurers in the Health arena. In his last position before becoming a consultant, Kevin ran the Accident and Health Reinsurance division for a major A-rated life insurer. Kevin's worked has included the pricing of a wide range of medical products, the evaluation of managed care networks and managed care intervention programs, and the assessment of liabilities for insurers and employers. More recently, he has worked on issues related to healthcare reform and has been involved in the preparation of bids for demonstration projects related to new healthcare initiatives. Mr. Gabriel has a BA from Wesleyan University in Middletown, Connecticut, and an MBA from the Wharton School of the University of Pennsylvania. In addition, he is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

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